UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

PETER ALLEN, et al.,

Plaintiffs,

v. 19 Civ. 8173 (LAP)

NEW YORK STATE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, et al.,

Defendants.

----------x

New York, N.Y.
February 7, 2023
10:00 a.m.

Before:

HON. LORETTA A. PRESKA,

District Judge

APPEARANCES

LAW OFFICE OF AMY JANE AGNEW PC
Attorneys for Plaintiffs
BY: AMY J. AGNEW
JOSHUA L. MORRISON

NEW YORK STATE OFFICE OF THE ATTORNEY GENERAL
Attorneys for Defendants
BY: MICHAEL J. KEANE
IAN RAMAGE

WHITEMAN OSTERMAN & HANNA LLP
Attorneys for Defendant Dr. Carol Moores
BY: ORIANA L. KILEY
WILLIAM S. NOLAN
GABRIELLA LEVINE
JENNIFER M. THOMAS

THE COURT: Good morning, friends. Are we ready? Do we have a witness, do we have Mr. Khan here?

MS. KILEY: We do, your Honor.

MS. AGNEW: I think we have two issues, if the Court would entertain?

THE COURT: Yes, ma'am. Go ahead.

MS. AGNEW: The first is, yesterday, we had a stipulation on the record. I did submit a letter to the Court late last evening because I misspoke. It's about my pending motion about the belatedly produced records. When I asked for the stipulation, I said if they would stipulate to only use them for rebuttal purposes, I of course meant to say impeachment purposes. I did misspeak. I apologize to everyone here. If we could just amend the stipulation, I'd be appreciative.

THE COURT: I think everybody was tired; right? Is that okay with you, Ms. Kiley?

MS. KILEY: Your Honor, we would argue this is a binding stipulation. If I may be heard on this issue for a moment.

Plaintiffs' motion is premature. We haven't even offered any of the documents at issue into evidence, so I would argue that this motion is premature to have these documents precluded. A closer look at these records show that they are mostly in the form of the most updated pharmacy records for

every single witness that is being ordered to testify in this hearing. The current medications that these individuals are on goes to the heart of this PI, and frankly we're concerned that plaintiffs are looking to preclude this information.

If it seems to be a timing issue that is the problem, Ms. Agnew seems upset that she got these records three days ago before the hearing, but I would like to just highlight that, by way of example, Mr. Myriel, who came on the scene about two weeks ago, we didn't receive these documents until 8:15 p.m. the day before Dr. Moores was going to be deposed. She brought these issues to Dr. Moores' deposition, didn't even give my client an opportunity to review them and ask questions. So we asked for a date by which to exchange documents. Ms. Agnew adamantly said we are not going to exchange documents before the hearing. We gave them to her three days in advance, as is our obligation to do so under Rule 26.

For these reasons, your Honor, we would like to uphold our stipulation from yesterday.

THE COURT: Ms. Agnew.

MS. AGNEW: Your Honor, I don't think the question is about when Mr. Myriel's documents were tendered, we tendered them within 12 hours of receiving them from the facility. The documents that were produced to me from last Friday are dated far in advance of last Friday. I don't understand the onus of Bates stamping documents and sending them over to counsel, I do

it all the time. We had a deadline of January 31st, 2023, which we graciously extended multiple times to get them to respond to our requests. These are responsive documents. I don't understand the excuse. If they want to ask my clients what prescription drugs they're on, they're welcome to do that. Whether or not my clients know is a different issue, but that's not the problem. They can't just put the documents into the record now that they're given to me three days before an evidentiary hearing.

THE COURT: Ms. Kiley.

MS. KILEY: These are not documents responsive to plaintiffs' tenth demand for documents. These are documents we received in preparation for the hearing that we are obligated to turn over and that's what we did.

THE COURT: But we had back and forth about by when documents for the hearing would be exchanged.

MS. KILEY: Correct. I graciously asked the Court to impose a deadline and Ms. Agnew was very adamant there was going to be no exchange of exhibits before the hearing and that my office would receive her exhibits on the morning of.

THE COURT: I thought we had agreed to January 31st, and then that got extended; am I wrong?

MS. KILEY: The January 31st deadline was responsive to the document demands.

THE COURT: I see. Let me know when one of these

documents comes up and we'll see what we do about it.

MS. KILEY: Thank you.

MS. AGNEW: Your Honor, an issue we're having, as chambers knows, my office has worked very hard to coordinate these video conferences with different facilities and different providers. When we found out the defendants would be finishing their case in chief midday today, we arranged to move the testimony coming from the Marcy facility from Friday to this afternoon. We did work very hard to do that. However, the provider from Marcy is now saying she's not available because she has patients scheduled for Tuesday. We'll be as brief as possible, we'd really like the state's cooperation on this, Mr. Keane has been working very hard to try to accommodate us, but he's telling us the superintendent of the facility is saying she will not be produced. We need to move this case along and get it done.

THE COURT: We need to have that person produced today or tomorrow.

MS. AGNEW: Well, I wanted to do it today because we're going to fill up the time, your Honor.

THE COURT: That's all fine with me, but they can pick the time. How long is the testimony going to be?

MS. AGNEW: I agree. I don't see the direct being any more than an hour, an hour and a half.

THE COURT: How long do we anticipate the cross of

this witness?

MR. NOLAN: Your Honor, we are unsure because we're unsure of what the direct is at this point, but I don't imagine --

THE COURT: We're not going to be talking more than two hours.

MR. NOLAN: Maybe half an hour.

THE COURT: Let them pick the time, whatever time they want, we will do, even if it's lunch, I don't care.

Where's Mr. Keane?

MS. AGNEW: He just stepped out, your Honor. And he is working hard, your Honor.

THE COURT: I know. He did last week, too.

MS. AGNEW: I'm not trying to disparage his efforts.

THE COURT: My hero. Mr. Keane, would you let them know that the witness has to testify today. We anticipate it will not extend beyond two hours and let them pick what time they want. It can be the lunch hour, whatever time they want. Obviously, we want to finish by 5:00ish, but whatever time they want, we will accommodate.

MR. KEANE: That will be with respect to Amy Ferguson.

THE COURT: I know you've been working hard on the other people. Obviously, we would not like to upset that apple card either, but whatever works, it has to get done today. If there's something you need me to sign, you let me know.

MR. KEANE: Understood, your Honor. There is a domino effect and a lot of moving parts.

THE COURT: I'm sure that Mr. Khan won't mind if we interrupt him, he won't mind much anyway. We can do it this morning, whatever they want. If we go through lunch, that's fine, too. Thank you, Mr. Keane.

Are we ready for Dr. Khan?

MS. AGNEW: Yes.

THE COURT: Dr. Khan, would you stand, give your attention to Ms. Phillips, please.

AFSAR KHAN,

called as a witness by the Defendants,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: State and spell your name for the court reporter, please.

THE WITNESS: First name is Afsar, A-f-s-a-r. Last name is Khan, K-h-a-n.

DIRECT EXAMINATION

BY MS. KILEY:

Q. Good morning, Dr. Khan.

A. Good morning.

Q. Dr. Khan, would you please share with the Court your educational background.

A. I'm a physician, family-practice trained, have done family medicine, as well as emergency medicine since 2001. So

approximately 22 years of medicine.
Q. Where did you go to medical school?
A. In Pakistan.
Q. And when did you complete medical school?
A. 1996.
Q. And where did you do your residencies?
A. Saint Elizabeth Medical Center in Utica, New York.
Q. Can you tell us a little bit about your employment history.
A. Sure. I have done a couple years of primary care and I have done the majority of the time in emergency medicine. I have worked in Saint Elizabeth Medical Center and Saint Luke's emergency department, both the ERs. For the last six years, I'm the medical director for both the emergency departments, as well, too.
Q. What does your role as the medical director in those organizations mean?
A. I oversee the emergency department providers, patient care.
Q. And when did you become employed with the Department of Corrections?
A. November 2020.
Q. And what position did you begin with in 2020?
A. As a clinical physician 2.
Q. Which facility were you assigned?
A. Mohawk and Walsh.
Q. Can you please explain for the Court how you were assigned

to two facilities?

A. Mohawk we call the GP, and then the Walsh is a higher security and have sicker patients in Walsh medical unit.

Q. For the record, what do you mean by GP?

A. General population.

Q. Is Walsh a regional medical unit?

A. Yes.

Q. What does that mean?

A. The patients who are really sick who cannot stay in the general population are into the setting where they need a lot more care and treatment.

Q. And these two facilities, where are they located geographically?

A. Walsh RMU is actually located inside Mohawk.

Q. Are they connected or are they in different parts of the facility?

A. They are connected.

Q. Have you worked in any other facilities?

A. No.

Q. Have you taken on any other roles since November of 2020?

A. Yes. In 2021 of November, I became the facility health director for Mohawk and Walsh, which means I was overseeing the physician staff at Walsh, as well as doing the clinical medicine, as well, too.

Q. Can you explain a little bit more what you mean by oversee

staff as facility health services director?
A. So it's the clinical role, which means that, you know, if they have any clinical questions, the providers in that facility come up to me and answer all their questions, guide them with the clinical medicine, as well as if there are any administrative support they need like schedules and time off. So we handle those situations, as well.
Q. For how long were you the facility health services director?
A. For one year.
Q. What is your current role?
A. I am doing, as deputy CMO for Dr. Moores in central office, as well as I'm doing clinical medicine in Walsh, as well.
Q. So how much of your time is split, meaning is it 50 percent clinical work and 50 percent central office work or something else?
A. No, that's correct.
Q. So how many days a week are you at the facility doing clinical work?
A. Two days.
Q. Are you there for the whole day?
A. Yes.
Q. How many hours?
A. About 20 hours.
Q. A week?

A. Clinical medicine, 20 hours, and then administrative in Dr. Moores' central office is 20 hours, as well.

Q. Can you describe briefly for the Court your duties as deputy chief medical officer.

A. Since I joined the central office, looking into the policies, updating the policies, as well as looking through the procedures and trying to make the procedures better.

Q. In your role as deputy chief medical officer, have you visited other facilities, besides the ones that you are assigned to?

A. Yes, I have.

Q. Approximately how many facilities have you visited since becoming the deputy chief medical officer?

A. About seven to ten.

Q. And what do you do on your facility visits in this role as deputy?

A. We engage the providers working in those facilities, provide them the support, also guidance and find out what their needs and struggles are and try to help them out with whatever their needs are in that facility. Also speak to the administrative side of the facilities, as well, too, which includes the superintendents and see what their needs are and try to help them out, as well, through the central office.

THE COURT: This is not a race, doctor. My friends here are taking down the words, you're talking a little fast.

THE WITNESS: Okay.

THE COURT: Thank you.

THE WITNESS: Sure.

Q. Can you recall which seven facilities you have visited thus far?

A. There is a Mid-State, Marcy, Lakeview, Shawangunk, and there's a couple more.

Q. What are some examples of some of the questions that some of the providers have asked you during these facility visits?

A. I think those are very basic questions they have. Nowadays, we have a MAT program going on through the central office, which is the medication assisted treatments. So a majority of the questions are regarding the MAT program.

THE COURT: Doctor, I'm going to ask you to move a little closer to the microphone and to just slow it down a little bit.

THE WITNESS: Sure.

Q. What is the nature of the questions specific to the MAT program?

A. I think it's just need some guidance about the MAT program. They need how to treat the patients, the dosage, the scheduling of the medications, different formulations, side effects, benefits. So those kind of questions.

Q. I want to now switch to talking about your duties as a clinical physician 2 at Walsh. How many patients do you see in

a day?

A. We will probably see between 15 to 20 patients.

Q. When you say we, who are you referring to?

A. Actually, we have midlevels, other providers work with us. So we work as a team. So we round together. Especially myself, round with two midlevels. So if they have any questions, I give them a guidance and oversee those midlevels, as well.

Q. For the record, what do you mean when you say midlevels?

A. Nurse practitioners and physician assistant.

Q. How many physicians, besides you, are assigned to Walsh?

A. We have total of seven providers which are working in Walsh.

Q. And do those providers also provide care for Mohawk?

A. Once a while, if there's a need for somebody in the location in Mohawk, we usually go out and help out in Mohawk, as well.

Q. How many physicians are assigned to Mohawk?

A. I believe it's four or five, combination of full-times and part-times.

Q. How many midlevels are at Mohawk?

A. I believe there's at least two to three.

Q. So do you communicate with all of the staff that you've just mentioned on a daily basis?

A. Yes.

Q. And you testified a moment ago that you make rounds. What do you mean by rounds?
A. Myself and one or two midlevels, we have our list of patients and we go from unit to unit together. Then we make rounds with the nursing staff and find out what the issues are with the patients and we treat them accordingly.
Q. Do the rounds include observations of other providers treating patients?
A. Yes.
Q. Do you provide feedback to the providers after you watch them provide care to a patient?
A. Yes.
Q. Generally, what is the purpose of making rounds?
A. I think it serves two different purpose. One is the clinical supervision or clinical medicine doing myself, as well as overseeing my colleagues at the same time. It also provides support for the midlevels, as well, too.
Q. How often do you make rounds?
A. When I'm there every day. So now it's twice a week.
Q. So just to clarify, you don't make rounds because there was an issue that you need to look into?
A. Those are regular rounds every day I will make for clinical medicine, yes.
THE COURT: Can I ask a question. In the facility, when you say rounds, and it conjures up being in the hospital

going from room to room, do the patients come to you in one space or do you visit them?

THE WITNESS: In Walsh, we visit them.

THE COURT: Thank you.

Q. I believe you testified earlier that the patients at Walsh, and forgive me, I don't know if you said very sick or they're very complex patients, can you help us understand what you mean by that?

A. I think of it multiple medical problems. Some of them are acute, majority of them are chronic medical problems. They have some physical disabilities. So their overall picture of their health is very complex.

Q. Given your role and what you've just described as far as making rounds and all of your communication with other providers, in your current role, do you review the records of patients that are not in your care?

A. Yes.

Q. And why is that?

A. I think for couple different purposes. As a facility health directors, we are supposed to review ten charts every few months to make sure the quality is maintained and there is proper documentation so we can give feedback to the providers.

Q. Are there any other circumstances that you review the medical records of patients that are not in your care?

A. If midlevel brings a concern to my attention or nursing

staff brings, you know, an issue or concern to my attention, those are the other reasons to review those records, as well.

Q. And you testified earlier that you were the facility health services director I believe for one year. Are you still reviewing medical records on a monthly basis?

A. Yes.

Q. And why is that?

A. For same reasons, for providing feedbacks, as well as guidance and overseeing the care of those patients.

Q. I want to talk about the medications with abuse potential policy. Dr. Khan, do you recall the MWAP policy being in place?

A. I believe very briefly when I came on board for very short period of time.

Q. And what was your understanding at the time of the MWAP policy?

A. I think the only thing I remember is we just have to fill up an extra form for some medications. That was it.

Q. Do you recall making MWAP requests yourself?

A. Probably once or twice.

Q. Do you have any recollection of whether or not those medications were approved or denied?

A. They were approved.

Q. Did you have any issues with the MWAP policy?

A. No.

Q. Do you recall when the MWAP policy was rescinded?
A. Yes.
Q. Do you recall how that was communicated to you?
A. Yes, it was the communication from the central office.
Q. Did you discuss the change with anyone?
A. With the providers and the midlevels at the facility, yes.
Q. Do you have recollections of those discussions?
A. We have monthly meetings, provider meetings, as well as the dep of health has their own monthly meetings, as well, too. So the policy was discussed in provider meetings as well as the health meeting, as well.
Q. What do you recall, if anything, about the substance of those conversations?
A. It was discussed, the MWAP policy has been discontinued and we don't have to fill up extra forms for the medications.
Q. Do you recall learning about policy 1.24A?
A. Yes.
Q. How was that communicated to you?
A. It was through the central office, as well as through the superintendent's office, as well.
Q. Do you recall having any discussions about 1.24A?
A. Yes. Provider meetings and the DEP of health meeting.
Q. What do you recall about that transition away from MWAP and to the 1.24A policy?
A. I don't think there was any big difference, we just didn't

have to fill up an extra form. That was the only change we noticed.

Q. I want to talk about some parts of the 1.24A policy. You testified earlier that you see about 10 to 20 patients in a day. How often would you say you see patients specifically for pain?

A. I think when it comes to the pain patient, it's just the part of the regular patient's evaluation. Once we are making rounds, if the patient's list of diagnoses say it's a chronic pain, that's just an additional diagnosis they have in their list of diagnoses.

Q. Before you see a patient, what documents, if any, do you review before you go and see a patient that's scheduled?

A. I think the chart -- the front portion of the chart has all the diagnoses written for the same patient on the first page, and we look at those first pages about all these diagnoses and then we know exactly what's going on with the patient. Once you are seeing those patients frequently, you already know what's, majority of the time, wrong, the diagnoses of those patients.

Q. And if you see code 338 on a medical problems list, what does that mean to you?

A. I believe it means -- we call it pain patient, but there are so many codes that we pay so close attention to these codes, I think we pay close attention to the written diagnosis

of the patient. That's what we -- usually, providers go by those diagnoses.

Q. So if you see 338 on a medical problems list before you go and see a patient, does that change anything about the way you're going to provide care for that patient?

A. It's just an additional diagnosis they have. This should not affect the care of the patient by any means.

Q. And if you review a medical problems list before you go and see a patient and they don't have 338 on their medical problems list, but then they complain of pain, are you still going to provide care for pain?

A. Of course.

Q. To your knowledge, have any other providers you've spoken to not provided treatment because a patient didn't have 338 on their medical problems list?

A. No, that's not the case.

Q. Can you share with the Court very briefly on some of the commonly used pain medications that you've prescribed for pain?

A. Sure. I think it depends on the diagnosis of the patient. Pain can be acute, which is short-term, and the chronic, which is a long-term. Acute patients will last probably for few days to few weeks depending on the nature of the injury. The chronic pain will last a lot longer, which is on the basis of months and years. The treatment is the same way. For acute pain, the pain management is short-term. For the chronic pain,

the pain management is long-term. And the medication for both these purposes is used differently, as well. We can start from localized medications, which includes lidocaine patches or there's a lot of ointments used for the pain control to some simple pain medications, which includes nonsteroidal antiinflammatory patches or some medicines, which is commonly used as ibuprofen or Tylenol. Then we can go to some stronger pain medications, which includes some narcotics and muscle relaxants. So it depends on the clinical presentation of the patient and the clinical judgment of the provider.

Q. And is there any one, let's say textbook way of treating any one specific patient for pain?

A. I think everybody's diagnosis is different and the treatment is exactly according to the diagnosis.

Q. And in your experience, could two providers have different views on an appropriate course of treatment for the same patient?

A. Yes.

Q. And as a provider at DOCCS, is there anything preventing you from prescribing the medication that you believe to be appropriate for a patient?

A. No.

Q. To your knowledge, are the more commonly prescribed pain medications on formulary or non-formulary?

A. They are formulary, most of them are formulary.

Q. What does that mean?
A. For non-formulary, you have to fill another form, but for majority of the pain medications, you don't have to fill out any form by any means at all. You just have to write it down on the order sheet, the medications. That's pretty much it.
Q. Does formulary mean those medications are available to the providers?
A. Yes.
Q. If the pain medications that you described are all on formulary, what, if anything, stands between the patient and the provider's ability to prescribe that medication?
A. I don't believe so there is anything in between them except the clinical judgment of the provider and the diagnosis of the patient.
Q. I want to now talk about specialist recommendations. Dr. Khan, generally, what happens when you send a patient to see a pain specialist?
A. We make recommendations that patient needs to see a specialist for the pain management. We make that request through the system, it gets to the specialist, and we schedule the appointment for the patient.
Q. And what happens at the conclusion of a specialist visit?
A. Patient comes back with the recommendations and we look at the recommendations. Majority of the time, what we see is the specialist is just focused on one area of the patient's

management, but as a primary care physician, you look at the whole big picture of the patient and then decide from there.

Q. And so, are there times when a specialist recommendation might not be followed by the primary care provider?

A. I think the way it works is we come up with the best solution for that patient or best medicine or what's going to work better for that patient given the overall picture of his other medical problems, as well, too, because some of the medications might interact with other medications and we see the patients almost every day or multiple times a week, but the specialist only sees them once or twice a year. So he might not have as good of an overall picture of the patient as we have.

Q. And to your knowledge, are there providers that may not have followed a specialist recommendation every single time?

A. I don't believe so that's the case. I think we try to do what's best for the patient.

Q. In any scenarios that you're aware of that a provider is not following the recommendation of a specialist, to your knowledge, is that reason because of an RMD --

THE COURT: We're not going to lead excessively, are we?

MS. KILEY: I can rephrase.

THE COURT: Oh, good.

Q. Are the regional medical directors involved in approving

the recommendation of a specialist?
A. They are, yes.
Q. How?
A. I think they are involved in approving the consults only, but not the management of the patient at all.
Q. So I'm talking about the recommendation made by the specialist at the conclusion of a visit. Are the regional medical directors involved in following the recommendation of the specialist?
A. No, they're not involved.
Q. Dr. Khan, have you ever encountered a patient who does not agree with your treatment plan?
A. It's not uncommon to have those disagreements sometimes, but I think it comes down to good communication, good effective communication with the patient and the reasonings. So as long as we sit down, have the good discussion and explanation, I think, majority of the time, the patients do understand.
Q. Would it be appropriate for inappropriate for a provider to prescribe whatever a patient is asking for?
MS. AGNEW: Objection, your Honor. I think he can talk about his personal beliefs, but I think that this is getting a little wonky, experty.
THE COURT: I'm sorry. Is this an expert objection?
MS. AGNEW: Yes, your Honor.
THE COURT: Sustained.

Q. Have you ever prescribed a medication to a patient solely because they asked for it?
A. It's very difficult to prescribe what the patient asking -- as I said earlier, I think it depends what they need on their clinical, you know, exam, on the basis of clinical exam, yeah.
Q. You testified a moment ago about having a discussion with a patient regarding their care. Do you document every single word exchanged between you and a patient after a visit?
A. I think it's extremely difficult to write down a half an hour, 45 minutes of a conversation, but we try to write down the major points of it.
Q. And to your knowledge, based on the many medical records you've reviewed in your time as facility health services director, for example, are there times when there are providers that maybe haven't documented every single thing about their encounter with a patient?
A. Yes.
Q. And do you believe that those patients --
MS. KILEY: Withdrawn.
Q. In the times where you've seen that, did you have any reason to believe that those patients were not receiving adequate care?
A. No.
Q. Dr. Khan, what is your understanding of an annual evaluation for pain patients?

A. I think we evaluate these patients a lot quicker, a lot sooner on a regular basis, pretty much almost every month, every couple months. In Walsh RMU, we are supposed to do monthly rounds, every 30 days. During our monthly rounds, we ask the patients, we go over their list of medications, their diagnosis, and also if we need to address some medications, we do it. So it's usually happening a loot sooner than a year for sure.

Q. And if there were to be a formalized comprehensive annual assessment form, let's just say, would that change anything about the way that care is already provided to patients?

A. I don't believe it's going to change anything.

Q. Why is that?

A. As I mentioned earlier, we are making those rounds and recommendations a lot sooner on a regular basis.

Q. I'd like to talk about transfers when one patient comes to your facility for the first time. Have you ever done a medical intake for a transfer?

A. Sure.

Q. Can you describe that process?

A. A patient comes to the facility with a medication list and we go over the medication list. Whatever medicine they're already on, we continue those medications. Very rarely, if the medication is not available for some reason, that's not a provider thing, that might be a pharmacy thing because pharmacy

might not have every single medicine available all the time. So sometimes it takes them a few days to get the medication. Or if it's a weekend, Friday evening, so it might not get in until Monday morning. So sometime we can have tiny bit of a gap.

Q. Is there a requirement that a provider at a new facility has to reorder all of the medications prescribed from a previous provider?

A. Yes, we continue all the medication the previous provider has written, yes, at least in the start. Subsequently, when we examine the patient, that's the time if we need to make adjustment after talking to the patient, that's something different.

Q. Is there a difference in whether the medications from the prior facility are keep on person versus being administered one-to-one?

A. Sorry?

Q. Sorry. That was confusing.

Is it significant to consider whether or not the medication from the previous facilities keep on person versus one-to-one?

A. I think one-to-one rules are different, though. There are certain medications which are one-to-one, but certain medications are not one-to-one. So some medications, I'm not sure --

THE COURT: Can I just ask the witness, sir, you said that the one-to-one rules are different, certain medications are not one-to-one, and then I didn't hear what you said after that.

THE WITNESS: There are certain medications, like psychiatric medications, they are given to patients while we watch them taking those medications, but there are medications like antibiotics for dental pain, they just carry them with them to the dorm and they can take them when they need it.

THE COURT: Thank you.

BY MS. KILEY:

Q. If a medication is not ordered immediately upon transfer from a new provider, you testified a moment ago that sometimes they might not be available at the pharmacy, so my question to you is are there any other circumstances where a prescription might not be written at a new facility?

A. I can't foresee any reasons. Majority of the medicines are exactly written the same way once the patient arrives.

Q. Could a provider make a change after a physical examination of the incoming patient?

A. They can. I think everybody's clinical judgment and treatment can vary, it's medicine. So they can, talking to the patients and coming up with a solution to the plan, yes.

Q. I want to discuss now your role in supporting Dr. Moores. Are you involved in auditing?

A. Yes.
Q. Can you please explain your involvement.
A. We do the audits for the patients' charts, as we do already at the facility level. Then we do audits about the referrals, which are coming through the central office, we audit those referrals, as well, too. Those are pretty much --
Q. What are you auditing the referrals for?
A. Make sure they are appropriately documented or enough information is provided on those referrals.
Q. And what happens if you feel that a referral is not appropriate?
A. I think we pick up the phone and call the provider and have a conversation, get more history from the provider, as well, too. Then we come up with the best solution for the situation.
Q. How often have you had to do that since becoming deputy chief?
A. Quite often, a few times a day.
Q. Are providers receptive to that conversation?
A. Yes, they are.
THE COURT: In those conversations, doctor, are you saying essentially to the provider, I see here that you have referred this patient for a specialist review, I don't think that's appropriate, and have a conversation? Is it from that angle? It's not I think there should be a referral here and you haven't done it yet?

THE WITNESS: I think the referral is -- when I have the conversation, it's getting more information about the patient, what is the clinical situation of the patient and what is the best -- either the test or the medicine or the referral that patient can benefit from.

THE COURT: Do you end up approving the majority of those referrals or not approving the majority of those referrals?

THE WITNESS: I think since I have been taken this role, I have not refused any one of the referral at all. It's the conversation is based on what's the best thing is for the patient.

THE COURT: Thank you.

BY MS. KILEY:

Q. Do you review non-formulary requests?

A. Yes.

Q. How do you do that?

A. Central pharmacy sends us post-reviews, we look at the medication and we approve them once they are needed by the patient.

Q. Do you engage in the same dialogue that you just described for denials for non-formulary medications?

A. Yes. None of them get denied. There is no denial at all. We're just trying to find out what the best medication for the patient is.

Q. Dr. Khan, given the amount of communication that you have with the providers at the facilities all around the state, based on those conversations, have any providers communicated to you that they believe that they can't prescribe a medication because of a policy?

A. No.

Q. And based on those conversations, have any providers indicated to you that they feel they can't prescribe a medication because someone told them not to?

A. No.

Q. To your knowledge, are any providers still operating as though the MWAP policy still exists?

A. No.

MS. KILEY: I have nothing further.

THE COURT: Thank you. Do you want to take a break or what?

MS. AGNEW: I do, your Honor.

THE COURT: Why don't we take five minutes.

How long are you going to be about?

MS. AGNEW: 40 minutes.

THE COURT: Thank you. Mr. Keane, let us know when you know something.

MR. KEANE: I know 12:00 noon to 2:00 p.m. is the window.

THE COURT: Wonderful. We are on board.

(Recess)

THE COURT: Thank you, folks. Won't you be seated. Cross examination, please.

CROSS-EXAMINATION

BY MS. AGNEW:

Q. Good afternoon, Dr. Khan. We haven't met. I'm Amy J. Agnew. I represent the plaintiffs in this case. The fact that we don't know each other probably says a lot about how you practice medicine. It's a pleasure to meet you.

A. Thank you.

Q. I just want to ask you, have you read the complaint in this action?

A. The complaint, I was mentioned by the attorney.

Q. So my question was, have you read it?

A. I did not read it, no.

Q. Do you understand what the plaintiffs in this case are alleging, what they're complaining of?

A. I think the MWAP policy, the medication for abuse potential policy, having issues with that policy in the past.

Q. Do you have an understanding of what their issues were with the policy?

A. I believe the medications were getting denied in the past for pain control.

Q. Is it your understanding that patients suffered or are claiming that they suffered when these medications were denied?

A. I can't speak for what happened before I joined the DOCCS, very hard to tell.

Q. Let's talk about that moment. Actually, I'm going to talk about before you joined DOCCS. I think you testified that your training is in family medicine; correct?

A. Yes.

Q. Are you board certified in anything?

A. Yes, family medicine.

Q. Are you board certified in pediatrics?

A. No.

Q. And I think you said that you did your residency at Saint Elizabeth Medical Center?

A. Yes.

Q. And then I think you testified that you've worked in emergency rooms; correct?

A. Yes.

Q. Including at Saint Luke's; is that correct?

A. Yes.

Q. Is it true that Saint Luke's takes in prisoners from some DOCCS facilities when they need to be seen on an emergent basis?

A. I believe all the facilities takes prisoners from DOCCS when they come in for any emergency situations, they can go to any local hospitals.

Q. And I think you testified that you were the medical

director of Saint Luke's emergency room; correct?
A. Yes.
Q. Can you just tell us, what did you do as a medical director of the emergency room?
A. Do clinical medicine, as well as look at the management of the department and oversee the providers, as well.
Q. And were you serving in a clinical role when you were working in the emergency room?
A. Yes.
Q. And so, in your clinical role, were you seeing patients?
A. Yes.
Q. And in your clinical role when you saw a patient, would you call a specialist if you felt it was needed to examine the patient and give a recommendation on treatment?
A. Yes.
Q. How often would you say that happened, just ballpark?
A. 30, 40 percent of the time.
Q. Can you just, to give us an idea of how that worked, what kind of specialist would you refer with?
A. Depends on the diagnosis of the patient, if they're having MI, which is heart attack, we call the cardiologist. If they're suffering from trauma, we can call the trauma surgeon, as well. If they're having a stroke, we call the stroke specialist.
Q. When you were giving clinical care within the emergency

room, were you the primary care provider, so to speak, for that patient?

A. Yes.

Q. And in your practice in that emergency room, would you often refuse to follow the recommendations of the specialist that you brought in?

A. We can give them our input, as well, too, what's going on with the patient. I think it's a teamwork between us and the specialist.

Q. When you say teamwork, you would consult with the specialist; correct?

A. Right.

Q. You'd give your input on the kind of medical background of the patient and the specialist would give you his input on his specialty; correct?

A. Right.

Q. And is it often that you would disregard the recommendations of the specialist?

A. If we disregard them, we have to have a conversation and the reasons behind it.

Q. How often would that happen that you would come to the conclusion that the specialist was not acting in the best interests of the patient?

A. Very rarely, but disagreements do happen, but that's why we communicate with each other to come up with the best solution

for the patient.

Q. And so, the success of that relationship was about communication?

A. That's correct.

Q. So can you tell me, if you remember, your start date with DOCCS?

A. November 2020.

Q. Can we agree, sitting here today, that the MWAP policy was rescinded in February of 2021?

A. Yes.

Q. So you were with DOCCS for a very short period of time when MWAP was actually in effect?

A. Yes.

Q. Isn't it true, sir, that you actually only submitted one MWAP request during that time period?

A. I can't recall, but probably more than once. I can't recall exactly.

Q. Would it refresh your recollection if I told you that one MWAP request form was for baclofen?

A. I can't really recall at this point, yes.

Q. Can you tell me, is baclofen a controlled substance?

A. Baclofen is not a controlled substance.

Q. Can you describe for the Court what baclofen does?

A. It's a muscle relaxant.

Q. So when you first came in in late 2020, were you

immediately assigned to the Walsh regional medical unit?
A. Yes.
Q. So I don't think we really got into this, but we really need to detail for the Court what the Walsh regional medical unit is. Isn't it true, sir, that that regional medical unit operates like a hospital?
A. It's not really the hospital, it's just the patients are more complex in that place.
Q. How does a patient get admitted to Walsh?
A. They can be admitted from multiple different sources. They can be from another facility or they can be from the hospital, as well, too.
Q. Does someone make a recommendation for a patient to be admitted to Walsh?
A. Recommendations can be made either from the central office or from the sending facility, as well.
Q. And what are some of the circumstances that prompt a patient's admission to Walsh?
A. It could be medical condition, it could be a physical limitation, it could be either one of them.
Q. And isn't it true that the patients in Walsh, generally speaking, demand a higher level of care than patients in the general population?
A. Yes.
Q. And isn't it true that the patients -- well, let me go

back. Strike that. I apologize.

There's approximately 130 beds at Walsh; correct?

A. Yes.

Q. So 130 beds, does that mean, at most, there's 130 patients housed at Walsh?

A. Yes.

Q. Based on the facilities that you've visited, is Walsh smaller or larger than most facilities?

A. I think it's a decent size. I think, I'm not sure exactly, but it's the largest one we have, probably.

Q. And I think you're comparing it to other RMUs; correct?

A. Yes.

Q. How many RMUs are there in the DOCCS system?

A. I might not know the exact number.

THE COURT: Ballpark.

Q. Let's do this, sir. Do we have Wende RMU?

A. Yes.

Q. Do we have Fishkill RMU?

A. Fishkill, yes.

Q. Do we have Coxsackie RMU?

A. Yes.

Q. And we have Walsh RMU?

A. Yes.

Q. Do you know of another one?

A. I think it's four or five. That's pretty much it.

Q. I don't know of another one, but maybe one appeared. So we've got four RMUs; correct?
A. Yes.
Q. What I want to do is ask you, is an RMU, in general, smaller, does it house more patients or less than a normal facility, one without an RMU?
A. It houses, of course, smaller number of patients, yes.
Q. So you also worked at Mohawk; correct?
A. Yes.
Q. Do you know what security level Mohawk is?
A. I think it's medium, if I believe.
Q. Do you know how many prisoners are housed in Mohawk?
A. I'm not 100 percent sure, but it varies quite a bit. So last time I counted, it was calculated between 600 or so, between 500, 600.
Q. So Mohawk roughly has three to four times the amount of patients that the Walsh RMU does; correct?
A. Yes.
Q. And we can agree that those patients in the Walsh RMU demand a higher level of care; correct?
A. Yes.
Q. And in the Walsh RMU, sir, isn't it true that the medical staff, they make up treatment teams; correct?
A. You can make treatment teams, yes.
Q. Does Walsh no longer use treatment teams?

A. Some providers wants to make their rounds independently, some wants to do it in the team fashion, like myself.
Q. Can you describe for the Court what a treatment team is?
A. It's going to be myself, midlevel, which includes a nurse practitioner, PA, together, so we make rounds together. Some providers, they just want to make their own rounds by themself.
Q. So at Walsh RMU, could we agree that a patient could be receiving care from actually a treatment team, just not a single physician?
A. I don't recall any treatment team, per se.
Q. Does Walsh no longer have treatment team meetings to discuss patients' care?
A. We have care plans conferences, which includes an RN and the provider.
Q. So can you describe one of those care conferences for the Court.
A. We select a few patients for the conference. The provider will head as that patient as well as the nurse who takes care of that patient are in that meeting to discuss taking that patient.
Q. What are the objectives of those meetings?
A. Go through the medical diagnosis of those patients and the treatment plan of those patients.
Q. And are those meetings scheduled?
A. Yes.

Q. Do those meetings take place at Mohawk?
A. They take place at Walsh.
Q. I'm going to ask you now again just about Mohawk.
A. Sure.
Q. When you work at Mohawk, do you have those care conferences about patients?
A. No, we don't.
Q. And I think you testified that once a month — and this is true I think of most RMUs, correct me if I'm wrong — somebody does a monthly report on the patient; correct?
A. Yes.
Q. And can you tell the Court what are the contents of that monthly report?
A. I think it's prepared by the nurse manager of the unit, which includes the census and the diagnosis of the patients, and the provider senses how many patients are provided there.
Q. Isn't it true that that report often details the diagnoses of the patient?
A. Yes.
Q. And isn't it true that report details any progress the patient has made in certain medical areas?
A. Yes.
Q. And isn't it true that that report also contains a treatment plan moving forward?
A. That's part of the care plan, yes.

Q. So isn't it true that the patients that are housed in RMUs are getting much more comprehensive medical care than the patients who are housed in regular facilities at DOCCS?
A. I think they have a different level of care. The RMUs use a different level of care, I would say, because of the complexity of the patients.
Q. How is the care at a different level, in what way?
A. I think the patients in GPR, low acuity patients. Some of them might not have any medical problem and some might have just pure psychiatric problems and some might have medical problems. When it comes to RMU, these patients might have five or six different diagnoses or treatment plans.
Q. And in the RMU, are the patients in the eight-by-eight cells with the bars on the front?
A. They have separate rooms with the doors.
Q. And isn't it true those rooms then have something akin to a hospital bed in it; correct?
A. Yes.
Q. And they have a call-bell; correct?
A. Yes.
Q. And then there's usually a bathroom appended to the room; right?
A. Yes.
Q. So it much more, in an RMU, mimics a hospital room than the cells that the patients in regular facilities are housed in;

correct?
A. Yes.
Q. And I think you testified you do rounds for your patients on a pretty regular basis; correct?
A. Yes.
Q. When you're at Mohawk, are you doing those rounds?
A. No.
Q. At Mohawk, how did you see your patients when you were working there?
A. A patient comes, a patient will have a scheduled appointment. They can schedule the appointment through the call-out list and then they schedule their providers to come into the office and see us. We examine them and make treatment plans from there and then follow up on those patients, as well.
Q. How often did you see a patient when you were working at Walsh, generally?
THE COURT: Are you asking Walsh now or are you asking Mohawk?
MS. AGNEW: I'm asking Walsh. Oh, thank you, your Honor, I am asking about Walsh.
THE COURT: I'm really following.
MS. AGNEW: Thank you. You're on it, I'm not.
Q. Dr. Khan, I apologize. I am asking about Mohawk.
A. I only go there if there is a shortage for the physician or somebody's on vacation, I cover those vacations for a week or

maybe a few days in a month.

Q. So you weren't, quote-unquote, assigned to Mohawk; correct?

A. Yes.

Q. And I think you talked about the number of physicians at Mohawk; correct?

A. Yes.

Q. And what was that number again?

A. There are, I think, three providers and two midlevels.

Q. And you said there were approximately 600 patients at Mohawk; right?

A. Yes.

Q. And we've got three MDs, medical doctors?

A. Yes.

Q. And then two midlevels?

A. Yes.

Q. And I think you testified that you've been to Marcy; correct?

A. Yes.

Q. So do you know off the top of your head how many patients are housed at Marcy? I'll say prisoners.

A. No, at this point, I don't remember the total number. Approximately, I think same number, 500 to 600.

Q. Would you have reason to believe, if I was wrong, if I said it's approximately 900?

A. You could be right because I don't know the exact numbers.

Q. That's fair. So can you tell me how many physicians, right now, are assigned to Marcy?

A. We have two full-time providers there.

Q. I didn't ask you that.

How many physicians, medical doctors are assigned to Marcy?

A. There's no physician at this time, but we hired one just recently.

Q. You hired one. When is that one going to start?

A. The application is complete and I think 8 of March is his date of start.

Q. And then you mentioned two other providers who are at Marcy right now. Who are they?

A. Two midlevels.

Q. And what's a midlevel?

A. Nurse practitioner or a physician assistant.

Q. Would I be wrong if I said there's two nurse practitioners, Brandi Lynn Corigliano and Amy Ferguson?

A. Yes.

Q. And you visited there in the last six months; correct?

A. Yes.

Q. How many times?

A. At least two or three times.

Q. During those two or three visits, did you discuss with that staff policy 1.24A?

A. They already are aware of this policy, 1.24A, yes.
Q. How do you know they're already aware?
A. I think we spoke about it, not in an official meeting manner, but just in conversations with the providers there.
Q. What was the substance of those conversations?
A. About the -- I think majority of the conversation was about the MAT program, which we just recently started in the DOCCS, and when we were talking about the MAT program, the MWAP policy also came through, and we talked about that one, as well.
Q. Tell me this, is the MAT program intended to be for pain management?
A. No, it's for addiction medicine, for addiction.
Q. Can you tell me why would a conversation about MAT come up in the context of discussing 1.24A or vise-versa?
A. I think it was just another part of the whole conversation that, you know, we can prescribe any medicine the patient wants and the policy has been rescinded in the past and there's a new policy in effect. So we were having just general conversations about these things, about the changes.
Q. Isn't it true those conversations took place in October of 2022?
A. There was -- when I was a facility health director in Walsh, yeah.
Q. Do you know, approximately, the date?
A. I can't remember the exact date. Usually it's part of the

monthly provider meeting.

THE COURT: Was it in 2022?

THE WITNESS: 2020.

MS. AGNEW: He believes it was in 2020.

Q. Sir, I'm going to direct your attention to --

MS. AGNEW: It bears stamp P1, your Honor. This has already been admitted into the record as D2.

Q. Sir, that's right in front of you. All of our memories are a little faulty, including my own. If you want to look at this policy, sir. Just, first of all, tell me, do you recognize it?

A. Yes.

Q. Can you tell me when 1.24A was promulgated according to this policy?

A. 2/8/21.

Q. So is it possible your conversation with your providers happened after February 8th of 2021?

A. Yes.

Q. Is it possible that conversation actually took place in October of 2022?

A. I can't recall. I can't recall.

Q. When you had that conversation, did you ensure that each of those midlevel providers understood every aspect of this policy?

A. It was just a general conversation. I can't recall if there was any specifics about the details of the policy.

Q. Did you ever hear about any problems with compliance with 1.24A at Mid-State or Marcy?
A. I did not hear any issues, no.
Q. Were you ever charged with making sure that the medical providers at Mid-State and Marcy understood policy 1.24A and how it should be implemented?
A. I was -- my belief, they already knew about the policy when it came out. So if they had any further questions, they were -- I was always available for them to reach out to me if they have any questions.
Q. Did you ever ask them explicitly if they had any questions about policy 1.24A?
A. I did not ask them, no.
Q. I'm going to take you back to the moment when this was promulgated. Actually, let's go back.

I think we discussed the fact -- and this is just that you submitted one or two MWAP request forms; correct?
A. Yes.
Q. But from late 2020, you were at Walsh RMU; correct?
A. Yes.
Q. Isn't it true that there are patients housed at Walsh RMU for palliative care?
A. Not all of them. There is a very small number that would be on palliative care.
Q. Can you tell the Court what palliative care means?

A. Palliative care is the management of the end stage of a patient's life. Most likely, they have a terminal diagnosis.
Q. I think that might -- I want to know why you didn't submit more MWAP request forms when you were working at Walsh RMU from late 2020 until early 2021 when it was rescinded.
A. I believe -- it depends on how the palliative patients are coming to us. Sometimes we might have one or two patients in a month and sometimes we might not have any patient on palliative care at all. It's very variable.
Q. Isn't it true under the MWAP policy that prescriptions had to be renewed every 30 days with another request form?
A. Yes.
Q. So during that period, if you only submitted one form, approximately how many patients were you assigned?
A. I had about 20 patients.
Q. And none of those patients required MWAP medication during that time period except for the one who you got baclofen for?
A. It might have been those patients did not require any medication. It was pretty common, it's not uncommon at all that not every single person is going to be on the long-term pain medications.
Q. We can agree on that.
When you started working at Walsh RMU, did you receive any training?
A. Well, I was orientation, yes.

Q. And orientation is like two weeks for DOCCS orientation; correct?
A. Correct.
Q. Was there any other physician or doctor who trained you?
A. It was just the orientation about the place and some about the rules and regulations about the place kind of thing.
Q. What are you speaking of when you say rules and regulations?
A. Like what the process is, how you make the rounds, documentations, orders, how to write monthly orders, how to place the consults, those kind of things, which is quite different from when you come from the community.
Q. Who introduced you to the health services policy manual?
A. It was the -- Dr. Samad was the facility medical director at that time, as well as the nurse manager at that time.
Q. And did you review the health services policy manual when you on-boarded to DOCCS?
A. Yes.
Q. Did you sign anything that verified that you had read the manual?
A. Yes.
Q. What did you sign, do you recall?
A. I think I signed some papers that I have received and reviewed the copies.
Q. So when you did that review, do you recall reviewing the

MWAP policy itself?

A. I reviewed it, yes.

Q. And did anything about the MWAP policy strike you as different than your prior practice?

A. No, it was just an extra form I have to fill out for these medications. There was nothing more than that, other than -- except another extra form if I need to submit other medications.

Q. Did you have any discussions with Dr. Samad or Dr. David Dinello about the prescription of MWAP medications in Walsh?

THE COURT: Slowly, please.

MS. AGNEW: Sorry.

A. Yes, just the extra form has to be filled out first for certain medications.

Q. That was the sum total of your conversations?

A. Yes.

Q. Did David Dinello ever tell you that you should think twice before you prescribe an MWAP medication?

A. No.

Q. Do you recall when 1.24A was promulgated, was David Dinello your RMD?

A. Yes.

Q. Did he ever show up at Walsh RMU?

A. I seen him a couple times since then, yes.

Q. Did you have discussions with him about patients?

A. Yes.
Q. I want you to take a look at the second document there that has a P58 on it.
MS. AGNEW: Your Honor, that's behind your exhibit tab at 58, I hope.
THE COURT: Thank you.
MS. AGNEW: For the record, this document bears Bates number OAGMWAP 101436.
Q. Dr. Khan, I'm going to give you a moment with this email. Okay, I'm not going to test you. We can refer back to it. Okay?
A. Sure.
Q. Dr. Khan, were you a recipient of this email?
A. Yes.
Q. And isn't it true, Dr. Khan, that a lot of your colleagues at DOCCS were also recipients of this email?
A. Yes.
Q. Before we get into the meat of it, what's the gist -- well, first, who's it from?
A. I believe it's from the RMD, Dr. Dinello.
Q. And can we agree that the date is February 3rd of 2021?
A. Yes.
Q. And can we agree that the subject is health services policy 1.24, medications with abuse potential?
A. Yes.

Q. What's the gist of Dr. Dinello's email?
A. I think he's mentioning about rescinding the policy for the MWAP and the form does not need to be filled up again. Those are the things he's mentioning, acute pain needs to be treated for seven days of medications and chronic palliative pain needs to be treated with what works better for the patient, and clinical judgment as well as the guidance by the specialist, as well, too, in there.
Q. In the first paragraph, can we agree Dr. Dinello writes: "The MWAP policy was been targeted in a class action lawsuit which has been litigated for months and months. Sadly, after this Monday to 8/21, it will no longer be in effect. On the plus side, no more MWAP request forms. On the negative side, this could open the floodgates for highly addictive medications to once again cripple DOCCS and, more importantly, enslave our patient population."

That language, do you think that was an encouragement for you and your colleagues to start prescribing the medications you felt best suited your patients?
A. No, it did not actually change anything because the language, people can use whatever they want. I think at this stage where we are with clinical medicine, everybody's adult, and these kind of language should not hurt my critical disagreement for what I'm going to decide for the patient.
Q. I didn't ask you if it affected you.

A. Okay.
Q. I'm asking you, did the messaging indicate.
A. Messaging, of course it is a negative message.
Q. And then in the last paragraph, can we agree Dr. Dinello writes, the specialists are there to, quote, guide treatment and not dictate care, so choose wisely.

Again, is that language encouraging you and your colleagues to follow the recommendations of specialists?
A. I think it's, again, the guidance is there by the specialist and it comes down to the provider's clinical judgment when they see the bigger picture.
Q. After Dr. Dinello left DOCCS' employment, did you, either in your role with Dr. Moores or in your own role as a facility health services director, discuss Dr. Dinello's messaging and what negative impact it might have on provider care?
A. I personally did not discuss. But whoever I talked to, the providers at the facility, I did not see or they did not see the concern they cannot prescribe any medication just depending on this email, language of this email, either before or after.
Q. Was there a concern that David Dinello had kind of cultivated providers not to prescribe these kind of medications?
A. I think you can try by these kind of messaging, but as I said earlier, a mature, good clinical physician will not compromise the health of his patients, regardless what the

other persons are trying to convey.
Q. I want to now talk about you discussed reviewing charts; correct?
A. Yes.
Q. Let's first talk about when you reviewed charts as a facility health services director. And let me make the record clear, you're no longer a facility health services director; correct?
A. I'm still doing the role until we find another person.
Q. So if I understood, half your time is at Walsh?
A. Yes.
Q. And then half your time is with Dr. Moores; correct?
A. Yes.
Q. So when you're at Walsh, I think you testified you pulled 10 charts every few months?
A. Right.
Q. And you review those; correct?
A. Yes.
Q. And then you were saying that you might then, if you notice problems, speak with providers?
A. Yes.
Q. Do you know if that is done DOCCS-wide?
A. I think it's -- the policy I think is we have to do it once a year for the DOCCS providers and midlevels.
Q. Okay. Who's "we"?

A. The facility health directors needs to review those records.
Q. So once a year, a facility health services director is going to pull 10 charts?
A. Yes.
Q. Some of these facilities, can we agree, have as many as 2,000 patients, don't they?
A. Yes. I'm not sure they go that far in numbers. I think majority of them are probably close to a thousand, maybe a little above or below a thousand.
Q. In your experience -- I can't talk about Walsh because we agree Walsh only has 130 patients; right?
A. Right.
Q. So 10 charts might give you a pretty good perspective of what's going on at Walsh; right?
A. Right.
Q. But would 10 charts give you a good perspective of what's going on at Green Haven that has 2200 patients?
A. I think a majority of those patients, as you mentioned earlier, they could classify them, a large number might not have any medical problems at all. So we pick up the patients who have the medical problems for those patients to review the charts.
Q. You're the deputy chief medical officer of DOCCS; correct?
A. Yes.

Q. Isn't it true that Green Haven has a unit for the physically disabled?
A. Yes.
Q. Isn't it true that Green Haven actually has a heightened acuity level when compared with other facilities?
A. Yes, they do.
THE COURT: You two could slow it down a little bit.
MS. AGNEW: Sorry.
Q. I want to go back to your role with Dr. Moores. Is it your understanding that you and Dr. Moores are supposed to be fixing the effects of MWAP?
A. I think the role we are trying to do is to keep up with the changing environments in the medicine. Medicine is something which is always changing and things change in medicine and in the DOCCS, as well, too. So by changing the policies, we are trying to keep up with the changes which are going on in the medicine, and this is an example of what that one is.
Q. Well, I'm talking to you specifically about this.
A. Sure.
Q. And I appreciate that both of you are doing a lot of work, I truly do. I want is to know if you understand that you have an affirmative role fixing the effects of the MWAP policy?
MS. KILEY: Objection, your Honor. There was no such testimony given by Dr. Khan, that that was his role as deputy chief medical officer.

THE COURT: That's the question, isn't it?

Do you need the question again, sir, or can you answer it?

THE WITNESS: Sure, let me have it.

Q. Do you understand that you have a role with Dr. Moores to affirmatively address the effects of the MWAP policy?

A. Yes.

Q. What is that role?

A. I think the role is to change ourself, as you mentioned earlier, the changing medicine. Medicine is something that's constantly changing, and I cannot speak for what's in the past, but the things in medicine have changed to the point where we need to update these policies, that's all we're doing. We're not only changing the policies, we're changing our procedures when it comes to these kind of diagnoses and managements.

Q. Have you taken any effort to identify the patients impacted by MWAP?

A. You know, I have not seen there was any difference, you know, before or after the policy changes. The patients who are getting treatment, depending on the clinical judgment of the patients -- of the providers and the diagnosis of the patients. So, if there is any issues, me and Dr. Moores are definitely going to look into that one.

Q. I'm going to ask my question again. I need you to answer the question, not tell me the thing you want me to hear. Okay?

A. Sure.
Q. Have you made any efforts to identify the patients impacted by MWAP?
A. Yes.
Q. What were those efforts?
A. Again, the policy change is the first thing, which has been done. MWAP is completely gone, it's not there anymore. So there is nothing between the patient and the provider at this point to prescribe if the patient needs any of the medications, regardless if it was MWAP or outside the MWAP.
Q. How does promulgating the new policy help you identify the patients impacted by MWAP?
A. I think it's the -- I think it's going to go back to the -- clinically, I don't think it's going to impact anything, though. Yes, we're going to encourage or we're going to make sure all the patients are getting what they need, but I can't specify the procedures.
Q. You can't specify the procedures because there haven't been any procedures to identify the patients impacted by MWAP; correct?
A. I think we -- let me just --
Q. Yes or no, is there a procedure to identify the patients impacted by MWAP? No one is judging you on it. Is there or isn't there?
A. We have the procedures in place. We're trying to audit the

charts of the patients who are on the, you know, chronic pain medications or requiring more evaluations. So there are things in place.

Q. Okay. Where is the list of the patients impacted by MWAP?

MS. KILEY: Objection, your Honor. We haven't established that there have been patients impacted by MWAP still today.

THE COURT: I think that the doctor is answering the questions as -- are you able to answer this question, sir?

THE WITNESS: Sure.

THE COURT: Please. Do you need it again?

THE WITNESS: Sure.

Q. Where is the list of patients impacted by MWAP?

A. I don't believe I have the list.

Q. Does somebody else have the list?

A. That's not -- I can't speak for anybody yet.

Q. To your knowledge, is there a list?

A. I am not sure.

Q. So you testified earlier, and I truly appreciated your testimony, that when a patient gets transferred in, you don't automatically discontinue medications; correct?

A. Yes.

Q. Not until you sit down, and I think you used the term "good effective communication," correct?

A. Yes.

Q. In what way, just for the Court, would that good effective communication be, how does that take place in that interaction?
A. I think it's you schedule a time with the patient, you sit down with the patient, examine them, look at their diagnosis, look at their treatment, and if you think that you want to try something different which might benefit them better compared to what they have in the past. So this is what you offer to the patients and document accordingly, as well.
Q. And I think you mentioned half an hour to a 45-minute conversation. Is that how long you speak with your DOCCS patients?
A. I think it's variable. It can go until, easy, half an hour to 45 minutes, sometimes they're more.
Q. Is that kind of the timeframe of your medical encounters with patients in the RMU?
A. It's not the routine every day, but there are certain patients who require a lot more interaction compared to some other patients. It's very variable from patient to patient.
Q. Do the providers in normal facilities have the luxury of half an hour to 45 minutes with each patient?
A. I think they have at least half hour.
MS. AGNEW: One moment, your Honor.
THE COURT: Yes, ma'am.
MS. AGNEW: Your Honor, I have no further questions on cross.

Thank you very much, Dr. Khan.

THE COURT: Off the record.

(Discussion off the record)

REDIRECT EXAMINATION

BY MR. NOLAN:

Q. Dr. Khan, Ms. Agnew just mentioned patients impacted by MWAP. Do you recall those questions?

A. Yes.

Q. She didn't say what she meant by impact, did she?

A. No.

Q. You don't know what was in her head when she said "patients impacted by MWAP," correct?

A. Yes.

Q. And when she asked you about a list of patients impacted by MWAP, you wouldn't know what to look for, would you?

A. Right.

MR. NOLAN: Thank you. No further questions.

THE COURT: Recross.

MS. AGNEW: Nothing further, your Honor.

THE COURT: Off the record.

(Witness excused)

(Discussion off the record)

MR. MORRISON: Your Honor, I believe the defendants are done with their case, we do want to make an oral motion for a judgment.

THE COURT: Ms. Kiley, do you folks rest?

MS. KILEY: Yes, your Honor.

THE COURT: Mr. Morrison.

MR. MORRISON: At this time, we would like to make an oral motion for --

THE COURT: It is deemed made now. You can argue it later.

Let's take a break before we get this witness going, please. Thank you.

(Recess)

AMY FERGUSON,

called as a witness by the Plaintiffs,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: Please state your name and spell it for the record.

THE WITNESS: Amy Ferguson, A-m-y F-e-r-g-u-s-o-n.

THE COURT: Ms. Agnew.

DIRECT EXAMINATION

BY MS. AGNEW:

Q. Good afternoon, Ms. Ferguson. I want to just start off with your educational background. If you can tell the Court, generally speaking about that, I'd appreciate it.

A. I received a bachelor's degree in biology and psychology from Union College in 1998, and a master's degree in RN family nurse practitioner from Massachusetts General Institute in

health professions in 2002 in Boston.

Q. Can you tell me, for the nurse practitioner master's, how many years did you attend school?

A. Three years post-bachelor program.

Q. Are you currently licensed in the State of New York?

A. Yes.

Q. Can you tell the Court how long have you worked for DOCCS?

A. 17 years.

Q. And just by way of background, we spoke the other day, correct, a couple weeks ago?

A. Yes, for the deposition, yes.

Q. Can you tell us, since you on-boarded to DOCCS, where have you worked, in which facilities?

A. I worked at Mid State Correctional Facility from 2005 until this past August, and since August, I've been at Marcy Correctional Facility.

Q. Just so the record is incredibly clear, that's from August 2022; correct?

A. Yes, that is correct.

Q. So you were at Mid-State for approximately 17 years; correct?

A. Correct.

Q. And were you always working as a nurse practitioner at Mid-State?

A. Yes.

Q. Are you considered by DOCCS to be a midlevel provider?
A. I believe so. There's several -- I don't know what officials are called, physician extenders, midlevels, I don't know. That's what the terminology is right now.
Q. For the record, you do not have a medical degree; correct?
A. No.
Q. Can you just tell the Court, in your clinical practice at Mid-State, what does a typical patient encounter look like?
A. So, if a patient comes to see me for diabetes, say, I would review their recent lab work, I would discuss their medication and their compliance, I would do an exam, I would discuss their (technical interruption) with them, talk about diet and exercise. That would be a chronic care visit. An episodic visit could be whatever they're presenting with, a cold, an infected toe, back pain. It depends on the visit.
Q. I'm going to ask you, this is not your fault, it's the connection. If you could speak a little more slowly and more clear. And I apologize.
A. Okay.
Q. It's just how this is working. Okay?
A. Okay.
Q. So, in addition to your medical encounters with patients, what other duties do you have as a nurse practitioner with DOCCS?
A. I'm sorry. Can you repeat. There's a really loud fan and

I was just asking if they can turn that down. Would you mind repeating that question. I'm sorry.

Q. Sure. I appreciate that.

In addition to your medical encounters, your clinical duties, do you have other duties as a nurse practitioner with DOCCS?

A. Meaning administrative duties?

Q. Yes, ma'am.

A. If so, then no. No.

Q. So, when you came into DOCCS, did you receive any specific training?

A. Yes.

Q. Can you describe that for the record.

A. In the clinical setting, I was trained by the physician that was here at the time as to how they operated in the clinic. In the correctional setting, I was given a weeklong introduction to corrections training.

Q. How about medical training, Ms. Ferguson?

A. I shadowed the doctor for several days as to how things worked in the correctional setting at Mid-State.

Q. Could you tell us for the record which doctor that was?

A. That was Dr. Ramineni.

THE COURT: Ms. Ferguson, are you able to spell that for us, please?

THE WITNESS: I believe it's R-a-m-i-n-e-n-i.

THE COURT: Thank you.

THE WITNESS: You're welcome.

Q. Can you tell us for the record, is Mid-State a medium security facility?

A. It is a medium security facility.

Q. Can you tell us approximately how many prisoners are housed at Mid-State, and I appreciate that that fluctuates.

A. Maybe 1100 right now.

Q. Generally speaking, when you were offering clinical services at Mid-State, how many patients were assigned to you?

A. We didn't have a set assignment of patients at Mid-State.

Q. And now that you're at Marcy, is that different?

A. It is different.

Q. And how is it different?

A. You split the alphabet. I have the alphabet from K to Z.

Q. You have the alphabet from K, K as in Khan?

A. Kool-Aid.

Q. Kool-Aid. Very good. Thank you.

Isn't it true nurse Corigliano has the alphabet A through J?

A. Nurse practitioner, yes.

Q. Yes. Thank you. I apologize.

Is there any doctor currently assigned to Marcy?

A. Dr. Khan is their go-to with any questions, but there is no physician employed at Marcy.

Q. What do you mean by Dr. Khan is your go-to with any questions?
A. He is our backup if we were to have any concerns or questions.
Q. Do you mean questions about patient care?
A. In general.
Q. Is it your understanding that within DOCCS, a nurse practitioner should be assigned to a doctor?
A. I'm not aware.
Q. So as of today, it's you and nurse practitioner Brandi Lynn Corigliano at Marcy; correct?
A. Correct.
Q. And the two of you see, between the two of you, 1100 patients; correct?
A. That is correct. No, Marcy has about eight or nine hundred patients.
Q. I apologize. You meant 1100 about Mid-State; right?
A. Right. You're asking about the patients at Mid-State.
Q. I'm sorry. You have approximately 400 to 450 patients yourself; correct?
A. I believe so. I never counted.
Q. That's okay. If you are having medical encounters in a day, approximately how many patients do you see?
A. Up to 12, but could be more with emergencies.
Q. Approximately how much time do you have to spend with each

patient?
A. As much time as I need.
Q. Just generally speaking, approximately how much time do you spend on a clinical encounter?
A. Could be anywhere from 5 minutes to 20, 25 minutes or longer depending on the needs of the appointment.
Q. When you have those clinical encounters, do you consult with the patient's chart?
A. Yes.
Q. And can you describe for the record what the chart is composed of that you have at your fingers?
A. It's the patient's medical chart. So it has their problem list, their medications, any previous notes from the past year, labs, consults, history and physical.
Q. And the chart that you keep with you during medical encounters, could we call that the active chart?
A. That is correct.
Q. And can you describe for the record what the inactive chart is?
A. Anything from a previous prison bid and/or anything older than a year old during their present bid.
Q. I want to speak for a moment, you have in front of you, I hope, your documents. I want you to look at P1.
A. Okay. I have to open it.
Q. Take your time. You are such a good player.

MS. AGNEW: We put a note not to open it until they testified, your Honor.

Q. Ms. Ferguson, a-plus, gold star.

THE COURT: Now you're going to scare her.

MS. AGNEW: I'm not going to scare her. She's tough. She's tough.

Q. Right, Ms. Ferguson?

A. Okay.

Q. Do you see the page that has P1 on it?

A. Yes.

MS. AGNEW: For the record, your Honor, that's already been entered into the record as D2.

Q. Can you tell us, Ms. Ferguson, do you recognize that document?

A. I do.

Q. What do you recognize it to be?

A. The DOCCS policy for chronic pain.

Q. Do you recall speaking with me about this DOCCS policy a few weeks ago when I deposed you?

A. I do.

Q. Since I deposed you, have you spoken with anyone from DOCCS or the Office of the Attorney General or otherwise about this policy or your testimony today?

A. No.

Q. So can you tell me, do you recall when this policy was

promulgated?
A. Just from the date, that it was February 2021.
Q. And when it was promulgated, did you understand this policy to be replacing another policy?
A. I don't remember.
Q. Are you familiar with the former MWAP policy?
A. I am.
Q. Could you describe what the MWAP policy dictated as you remember it sitting here today?
A. That dictated that there was a list of medications with the potential to cause abuse. If we wanted to prescribe those medicines, we had to complete a form and submit it for review and approval before the pharmacy would fill those medications. I remember that mostly going away, but that's what I remember.
Q. When you completed those forms, who did you submit them to?
A. They were submitted electronically, but I believe they were reviewed by Dr. Dinello.
Q. And at that time, was Dr. Dinello your regional medical director?
A. Yes.
Q. Do you recall, and it doesn't have to be an exhaustive list, but what kind of medications were deemed to be MWAPs under the policy?
A. Any narcotics, testosterone, Neurontin, baclofen, and I don't remember what else was on that list.

Q. Do you recall if cough syrups were on that list?
A. I don't remember.
Q. How about Imodium?
A. That was probably on that list, but I don't specifically remember.
Q. Can you tell us, sitting here today, what does Imodium do?
A. It stops diarrhea.
Q. And can you tell us, in your experience as a DOCCS provider, how is Imodium administered to patients?
A. Pill. Is that what you mean, what form does it come in?
Q. Yes.
A. It's a pill.
Q. And is Imodium, when it is given, given one-on-one?
A. I don't remember if it was necessarily given one-on-one. Maybe when it was on the list it was, but not always.
Q. Let me ask you, for the record, what does one-on-one administration mean?
A. They have to come to the medical building and take the medication in front of the nurse.
Q. Do you have any understanding of why some medications are one-on-one?
A. Because they can be abused and sometimes, like blood thinners need to be one-on-one for the same reasons so patients can hoard them and take them or harm themselves with those medications. Also, insulin and any medications that need to be

injected are also one-to-one.

Q. Can you tell us, for the record, what do you mean when you say can be abused?

A. Imodium, taken in large amounts, can be used to get high, something like that.

Q. Do you have any awareness -- I'm sorry.

A. I had --

Q. How much Imodium would a patient have to take to get high?

A. I'm not sure.

Q. Is there a way within the DOCCS medical system to test whether or not an inmate has taken an illicit drug?

A. There are tox screens.

Q. How is a tox screen done?

A. By urine.

Q. How about, are there screening tests for the amount of gabapentin in a patient's bloodstream?

A. We don't generally use that. They're not indicative of their level taking that I've been told. No, I never check for gabapentin levels in blood.

Q. But is the testing available if you wanted to do it?

A. It is available, it's not reliable.

Q. Who told you it wasn't reliable?

A. Physician. I don't remember. I couldn't specifically tell you.

Q. Do you recall when P1 was promulgated, did you receive any

training on P1?
A. I don't remember.
Q. Do you often receive training on new DOCCS policies?
A. Sometimes. This was at Mid-State, so not all the time.
Q. When you do receive training on policies, what form did that take?
A. At Mid-State?
Q. Yes, ma'am.
A. If they were printed out and laying in the nurses' station for us to read or if they were hanging in the nurses' station.
Q. How did the printing out of the policy offer you training on how the policy should be implemented?
A. I don't know. That was what was available.
Q. Would you sign a verification when you reviewed a policy?
A. When I read and reviewed a policy, I would, yes.
Q. Is that also the program at Marcy?
A. Marcy, they are left in central area for reviewing in the nurses station.
Q. When you were in Mid-State, were new policies always left there for you to review and then sign a verification?
A. No.
Q. Was there any set period of time when you had to review the health services policy manual and verify in some form that you had reviewed it?
A. Sometimes. I don't know if (technical interruption).

Q. Do you recall ever being prompted to review the health services policy manual and to verify that you had reviewed it?
A. I know we had to sign that we reviewed the clinical practice guidelines for primary care providers yearly, but I don't remember about the health services policy manual.
Q. Just for the record, those are two separate sources of documents; correct?
A. Correct.
Q. And is it true that both of those sources of documents are maintained on your computer system?
A. Yes, that is correct.
Q. When 1.24A was promulgated, do you recall changing any of your clinical encounter practices?
A. I don't recall.
Q. Do you recall a time when you started adding problem list code 338 to the medical problem lists of your patients?
A. No, I don't.
Q. Have you ever added code 338 to the medical problem list of your patients?
A. I may have, but I don't remember.
Q. Do you ever recall getting any direction, other than in this policy, that you should be adding problem list code 338 to the medical problem lists of patients who suffer from chronic pain?
A. No, I don't remember.

Q. You don't remember or you've never gotten any direction to do that?
A. I don't remember if I have gotten direction to do that.
Q. If you had gotten direction to do that, would you have done it?
A. Yes.
Q. So do you recall at any point in time systematically going through your patients and adding 338 to the medical problem list codes for your patients who suffer from chronic pain?
A. No, I do not.
Q. Ms. Ferguson, do you treat patients who suffer from chronic pain?
A. Yes.
Q. Looking at policy 1.24A, at the third paragraph, it also mandates that a provider, in the event that the PCP does not accept the recommendation of the specialist, that the PCP will document in the AHR regarding the reasons why the PCP does not accept the recommendations.

Have you ever received training, Ms. Ferguson, to make those recordings within the AHRs?
A. I don't remember. I may have.
Q. If you had received that training, do you believe you would have signed a verification that you received it?
A. If I received training, I would have, yes.
Q. Can you tell me, as practice, when you are not going to

follow the recommendation of a specialist, do you record the reasons why in the patient's AHR?

MR. NOLAN: Objection. She hasn't established that she doesn't follow the recommendations of a specialist.

THE COURT: I think she used the word "if."

MR. NOLAN: No, she said "when."

Q. Ms. Ferguson, do you always follow the recommendations of specialists?

A. I don't know if I would say always. It's up to our discretion per the policy and outside consults.

Q. Who's outside counsel?

A. Consults.

Q. I apologize.

And you referenced a policy. What policy is that?

A. The policy related to outside medical appointments.

Q. And what does that policy say about following the recommendation --

A. That's --

Q. Sorry. Let me finish.

-- about following the recommendations of outside specialists?

A. That outside consultants make recommendations and it's up to the medical providers in DOCCS to determine what is ordered.

Q. So, do you record if the specialist has made a recommendation you are choosing not to follow?

A. I've reviewed the consult, I write a note in the AHR related to the consult and what I'm ordering. Sometimes I will note the reasoning of why I'm ordering something or not ordering something, or sometimes I'll follow the recommendations, everything that they've recommended, and sometimes I omit something. If I don't think it's necessary or the outside providers may not be aware of what we have available in DOCCS.

Q. Do you always follow the part of policy 1.24A that says you should record the reasons why you're not going to follow a specialist's recommendations?

A. I don't know if I've not followed an in-clinic recommendation. So, I couldn't say that I (technical interruption) consult --

Q. Do you recall, when I took your --

A. -- consult. This policy is only talking about pain clinic consults, not every other consult.

THE COURT: Ms. Ferguson, I'm going to read the portion of the answer we were able to hear and then I'm going to ask you if you had completed it.

The question was:

"Q. Do you always follow the part of policy 1.24A that says you should record the reasons why you're not going to follow a specialist's recommendations?

"A. I don't know if I've not followed an in-clinic

recommendation. I couldn't say."

THE COURT: And then there's a portion missing. And then you said something about this is only talking about pain clinic consults, not every consult.

Would you tell us what else you said in that answer, please, ma'am.

A. Yes. I said it was a pain clinic consult. So this policy, 1.24A is specifically referring to when patients go out for a pain clinic appointment only. So I said when patients are brought out to a pain clinic specialist, I believe I followed their recommendations and write the orders that are recommended. I don't remember if I've disagreed with a pain clinic specialist and written the note in the AHR. So I don't know if I can answer always because your question said do I always, and I don't know.

Q. Do you recall when I took your deposition on January 12th of 2023?

A. Yes.

Q. And do you recall that Mr. William Nolan was present?

A. Yes.

Q. Do you recall that Mr. Ryan Manley was present?

A. Yes.

Q. And do you recall that we had a court reporter who was over the computer?

A. Yes.

Q. And do you recall being sworn in at that time to tell the truth in your testimony?
A. Yes.
Q. And do you recall me asking you:
"Q. Do you record if the specialist has made a recommendation you are choosing not to follow?
"A. Not always.
A. Okay.
Q. Okay. That was your testimony on January 12th of 2023; correct?
A. Yes.
Q. Can you tell me where in policy 1.24A it says that it applies only to pain management consults?
A. It just says specialty consults will be ordered as indicated for the evaluation and care of chronic pain patients. So that was my interpretation.
Q. Is it only pain management doctors who treat chronic pain patients?
A. Chronic pain is a fairly general term, so I don't know.
Q. Do you recall a patient named Aaron Dockery?
A. Yes.
MS. AGNEW: Mr. Dockery, can you look up at the camera and just wave, maybe drop your mask.
Q. Do you see Mr. Dockery in this courtroom?
A. I can.

Q. And do you know Mr. Dockery, Ms. Ferguson?
A. I know him, yes.
Q. How do you know Mr. Dockery?
A. I only know him because I was covering Ms. Corigliano's patients when she was away.
Q. So normally speaking, is Mr. Dockery your patient?
A. No.
Q. Can you look in that pile I gave you, and I apologize, there is a bound group of documents, and on the cover it says Aaron Dockery, DIN 15A3271, and I premarked it as P3.
A. Yes.
MS. AGNEW: For the record, this is a subset of Mr. Dockery's AHR at DOCCS.
Q. It is not complete, Ms. Ferguson, so I don't want you to believe this is an entire copy of that. Okay?
A. Okay.
Q. Can you tell us, sitting here today, are you familiar with Mr. Dockery's medical history?
A. I know he has multiple sclerosis.
Q. How did you come to know that Mr. Dockery had multiple sclerosis?
A. From his chart.
Q. When did you review his chart?
A. 2022.
Q. I'm sorry?

A. Probably in December of 2022.
Q. And can you tell me why you reviewed Mr. Dockery's active chart?
A. Because the nurse approached me that he was refusing mouth checks for his Neurontin and his baclofen.
Q. What do you mean when you say the nurse approached you?
A. (Technical interruption)
Q. I'm so sorry. We missed that part, Ms. Ferguson.
A. The nurse approached me to let me know he was refusing to let the nurse check his mouth to ensure he took the Neurontin and the baclofen.
Q. Who was the nurse who approached you?
A. Theresa Reilly.
Q. Did she have anything with her when she approached you?
A. I don't remember.
Q. When she first approached you, were you familiar with Mr. Dockery's medical history?
A. I don't think so.
Q. So when nurse Reilly approached you, what actions did you take?
A. Well, she told me over the course of several days. She told me the first time just to let me know and then I believe let me know after the third time, the third refusal results in a discontinuation of medication.
Q. Can you please explain to the Court what that means, the

third time a patient refuses, it results in a discontinuation of medication, where is that, is that a policy?

A. It is.

Q. Where is that policy written?

A. I don't know. Probably the medication administration policy.

Q. Who is supposed to discontinue the medications if a patient misses three doses?

A. The provider.

Q. And have you discontinued the medications of patients under those circumstances in the past?

A. Yes.

Q. Approximately how many times?

A. Many times.

Q. When you do that discontinuation, do you review the patient's refusal forms?

A. I may.

Q. Can you tell the Court what a refusal form is?

A. A refusal form is a piece of paper that an inmate signs or doesn't sign that refuses medication, treatment, trip.

Q. Isn't it true if a patient refuses either medication or a trip, a refusal form is supposed to be completed?

A. That is correct.

Q. So when you discontinue medications because a patient has missed three doses, do you always review those refusal forms?

A. I try to. I don't know if you're asking always.
Q. I'm not asking always, but generally, you look at the refusal forms; correct?
A. Yes.
Q. What if you don't have three refusal forms?
A. If the nurses documented that he's refused it three times, despite being called down, refusing to comply with the procedure, it will be discontinued.
Q. Do you look into why a patient might have not shown up at the med window?
A. If the patient mentioned why they were refusing the medicine, then it would be discussed, I would absolutely meet with them. If the patient is just refusing for the nurse to check their mouth to show they've taken their medicine, then that's their choice, but we have a job to do to make sure a medicine is taken and not diverted.
Q. Did nurse Reilly tell you why she believed Aaron Dockery was diverting his medication?
A. She didn't say that. She just said he was refusing to do a mouth check for the medication. She didn't tell me anything.
Q. And did you read Aaron Dockery's refusal form?
A. I don't remember.
Q. So what action did you then take?
A. I discontinued the medication because he was refusing the mouth check.

Q. Did you sit down with Mr. Dockery and discuss the fact that you were going to discontinue his medications?
A. No, he had already missed three to four days of doses at that point because he was refusing them when I discontinued them.
Q. When you discontinued the medications, did you review Mr. Dockery's chart to see why he was taking the medications?
A. No.
Q. So when you discontinued Mr. Dockery's baclofen and gabapentin, you had no idea why he was taking them?
A. He was refusing them. That's why they were discontinued.
Q. Did you know that Mr. Dockery was taking those medications to control his symptoms for his multiple sclerosis?
A. I believe he was taking Neurontin, which he chose to not take for four days before it was discontinued.
Q. Did there come a time when you sat down with Mr. Dockery and discussed his refusals with him?
A. No, he never said his concerns to sick call or the nurse. Had he, this would have been avoided.
Q. Say that again. He never reported any concerns to sick call or the nurse?
A. Right. If he had reported this issue about the mouth check and the flashlight, then we would have dealt with it at that time, but instead, here we are. I didn't know the issue was over a mouth check until we heard from legal.

Q. You didn't know the issue was over a mouth check until you heard from legal?

A. That it was over the flashlight. His complaint was because of the flashlight, apparently. The first time we were aware of that was when he came to legal, that through the sick call contact.

Q. Can you open up those documents I gave you, Mr. Dockery's, and they're imperfect, so bear with me, but if you could go to page 313, which is very much toward the back.

A. Yes.

Q. Do you see page 312, it says Aaron Dockery 312 on the bottom?

A. Yes.

Q. Do you see your handwriting on that page?

A. I do.

Q. And what is your handwriting memorializing?

A. Discontinue Neurontin and baclofen, secondary to refusal.

Q. When you signed that, did you meet with Mr. Dockery and ask him why he was refusing the medications?

A. No.

Q. Can we just flip one page over, it should be Aaron Dockery 314, but it was stamped upside down because I'm sometimes not good at my job and I apologize.

Can we agree that that is a note from Mr. Dockery to the nurse administrator?

A. Yes. I'm not the nurse administrator.
Q. I understand. And isn't this note dated December 8 of 2022?
A. Yes.
Q. So are you Mr. Dockery's normal provider?
A. No. Neither is the nurse administrator.
Q. I understand. When you discontinued Mr. Dockery's medication, would he have any way of knowing who discontinued it?
A. He wrote the letter on the 8th, I discontinued it on the 2nd.
Q. And what does that mean to you?
A. That means, to me, that he told us his reasoning six days after it was discontinued and nine days after he started to refuse it.
Q. Do patients at Marcy need a pass in order to go to the med line?
A. I believe they do.
Q. If you're looking at that, can a patient go to the med line if he doesn't have his pass without getting a ticket?
A. I don't know.
Q. Has anyone counseled you, and that's besides me speaking with you in our deposition, on not discontinuing patients' medications until you sit down and speak with them?
A. No, they have not.

Q. Now, looking back at policy 1.24A, isn't it true that the second paragraph from the bottom says, "Pain management medication should only be discontinued after a provider has met with the patient, discussed the issues regarding the use of the medication, analyzed the patient's situation, and subsequently determined that it is in the best interests of the patient for the medication to be discontinued"?

A. The patient refused the medication.

Q. I didn't ask you that, ma'am. I asked you if that's what the policy says?

A. Okay. That's what the policy says.

Q. Did you follow the policy when you discontinued Aaron Dockery's medication?

A. (Technical interruption) policy --

Q. Could you say that again. I apologize. You froze.

A. I followed the medication administration policy about medication refusals.

Q. Did you prescribe an effective alternative for Mr. Dockery to manage his symptoms from MS?

A. I did not prescribe anything.

MS. AGNEW: I have no further questions, your Honor.

THE COURT: Thank you. Cross examination, please.

MR. NOLAN: Real quick before cross, I don't know if you entered that into evidence.

MS. AGNEW: Thank you so much. I didn't enter it into

evidence, your Honor.

THE COURT: Yes, go ahead.

MS. AGNEW: I apologize. Your Honor, I'd like to move into evidence the pages from the group of documents premarked P3 at Aaron Dockery 312, 313, and 314.

THE COURT: Any objection?

MR. NOLAN: None.

THE COURT: Received.

(Plaintiffs' Exhibit P3, PAGES 312, 313, 314 received in evidence)

MR. NOLAN: Are you just moving in parts of it?

MS. AGNEW: Just those three pages.

MR. NOLAN: Why don't we move in the whole thing since we stipulated to the admissibility of the whole thing.

MS. AGNEW: No, just those three pages.

MR. NOLAN: We stipulated to the admissibility --

MS. AGNEW: You can use my exhibit, sir.

MR. NOLAN: Okay.

THE COURT: Cross, please.

CROSS-EXAMINATION

BY MR. NOLAN:

Q. Good afternoon, nurse practitioner Ferguson. Can you hear me?

A. Yes, I can. Good afternoon.

Q. Do you have P3 in front of you?

A. Yes, I do.
Q. Can you turn to page 309 at the bottom in the middle.
A. Yes, I see it.
Q. So you have 309 in front of you?
A. Yes.
Q. Can you just take a minute to familiarize yourself with that.
A. Okay.
Q. The top portion on page 309, can you describe what that says?
A. That the patient was brought to medical and possibly under the influence of an unknown substance. Slow to respond. It was a nurse visit on 11/9/22.
Q. And what does that indicate to you as a medical provider?
A. That means that he may have been high on something and brought to medical to be evaluated.
Q. Now, you talked earlier about the date that you actually discontinued Mr. Dockery's medications; correct?
A. Correct.
Q. When was that?
A. That was on 12/2/2022.
Q. So that was after the medical records indicate that he may have showed up high?
A. That is correct.
Q. And you talked a little bit earlier about what you said was

diversion. Can you describe what you meant?
A. That could be not taking your medication as prescribed, taking it back with you to your cell to sell or to use in large amounts for other purposes.
Q. And you indicated, I believe, that there were two or three occasions that Mr. Dockery, to your understanding, had refused his medication, his gabapentin and his baclofen; is that correct?
A. That's correct.
Q. And when, to your understanding, was it that he refused his baclofen and his gabapentin at the mouth check?
A. He had refused it, from what I can see, at least on 12/1 and 12/2 with the mouth check.
Q. So that was after he showed up to medical high?
A. Correct.
MS. AGNEW: Objection. It's after the notes say --
THE COURT: Fair enough, right?
MR. NOLAN: Fair enough, your Honor.
Q. Now, when a patient is refusing medication on multiple occasions in a short period of time, does that present any concerns to you as a medical provider?
A. I mean, if they're refusing their medication, it is a concern as to -- he was refusing the procedure of the medication administration.
Q. What does it tell you --

A. So --
Q. What does it tell you about their need for that medication when they're refusing it?
MS. AGNEW: Objection.
THE COURT: Basis.
MS. AGNEW: Didn't refuse the medication, he refused the mouth check, your Honor. She said that.
THE COURT: Sustained.
Q. What does it tell you when a patient refuses a mouth check for medication as to their need for that medication?
A. Well, if they don't want to comply with the DOCCS procedures of giving medication, which, to my knowledge, have always been that way, then they're refusing to follow the procedures that have been there. Then maybe they don't need it or maybe they have something else going on.
Q. Well, what else might be going on?
A. Diversion.
Q. In Mr. Dockery's case, with a patient who showed up high a month earlier --
MS. AGNEW: Objection.
THE COURT: Same objection, counsel.
Q. Having reviewed Mr. Dockery's medical records, is there anything that you could see now to suggest to you that there was a substantial risk of diversion?
MS. AGNEW: Objection.

THE COURT: Ms. Ferguson, when counsel objects, would you hold your answer, please, and let me rule on it.

THE WITNESS: I apologize.

MS. AGNEW: I'm going to withdraw my objection, your Honor.

THE COURT: All right. Here we go. Ms. Ferguson, do you need the question again?

THE WITNESS: Yes.

THE COURT: Having reviewed Mr. Dockery's medical records, is there anything that you could see now to suggest to you that there was a substantial risk of diversion?

A. Yes, possibly.

Q. And when presented with a substantial risk of diversion, do you, as a medical provider, have medical concerns about continuing that person's medication?

THE COURT: Is this an excessively leading question or a moderately leading question?

MR. NOLAN: This is a witness who's not represented by counsel today.

THE COURT: All right. I'm listening pretty hard. Okay.

What you said was, when presented with a substantial risk of diversion, do you, as a medical provider, have medical concerns about continuing that person's medication.

Do you want to stick with that or do you want to do

something else?

MR. NOLAN: I'll stick with that.

THE COURT: Ms. Ferguson.

THE WITNESS: Yes.

Q. What are those concerns?

A. The concerns are for the safety of the patient, that the patient does not take that medication back to take all at once to possibly overdose, that is the concern, or to sell some to somebody else that could possibly overdose. Those are our medical concerns.

Q. Do you have overdoses in your facility?

A. Yes, we do.

Q. How often?

A. We had a death recently.

Q. I just want to hit on a few other points, if you just give me a second.

With respect to the mouth checks that we talked about earlier, are you familiar with the procedure that is used generally in your facility for that?

A. Yes, from what I can see, the nurse holds a flashlight to the patient's mouth to ensure that the pill or strip or whatever has been swallowed or cleared out of their mouth.

Q. To your knowledge, how far away is the flashlight usually held?

MS. AGNEW: Objection.

THE COURT: Basis.

MS. AGNEW: He needs to establish that she's actually seen it happen.

THE COURT: Counsel.

MR. NOLAN: That's fair.

Q. Have you seen this happen?

A. Yes.

Q. And same question again, how far away from the patient's mouth is the flashlight typically held?

A. I would guess 6 to 12 inches.

Q. Is it typically put in the patient's mouth?

A. No.

Q. Would you be surprised if counsel for Mr. Dockery represented to this Court that the flashlight in question in this case was shoved in the patient's mouth?

MS. AGNEW: Objection.

THE COURT: Sustained.

MR. NOLAN: You don't have to answer that.

Q. Are you familiar or have you seen the flashlights that are used for mouth checks?

A. Yes.

Q. Are you familiar with the size and shape of the flashlight?

A. Yes, I am.

Q. Can you describe that for us?

A. It's probably at least 3 to 5 inches wide -- the length.

Q. Is it wider than, say, an inmate's mouth?
A. Yes.
Q. When you discontinued Mr. Dockery's medication, did you intend for that to be a permanent discontinuation?
A. No, I did not.
Q. We talked a little bit earlier about 338 codes. Do you recall that when Ms. Agnew was questioning you?
A. What codes?
Q. 338, problem list codes.
A. Yes.
Q. Does the appearance of a 338 code on a patient's chart impact how you go about treating a patient?
A. No.
Q. What does impact how you go about treating a patient?
A. Their medical needs, how they're presenting and what needs to be done. I don't treat patients with 338 codes differently than other patients.
Q. We talked a little bit about specialist recommendations. Do you recall that testimony?
A. Yes, I do.
Q. When, if at all, was the last time you can recall rejecting a pain specialist's recommendation?
A. I don't recall doing that.
Q. Do you have any reason to believe that you've ever done that?

A. No, unless it was something that was just unable to be done in the facility, but not any specific injections, medications, pain patches, we would follow that.

Q. You were asked earlier about your testimony at your deposition on January 12th, 2023. Do you recall that?

A. I do.

Q. And you were asked or reminded about your testimony with respect to whether or not you always follow the recommendations of a pain specialist; right?

A. Yes.

Q. And in your deposition, when you gave the testimony you did, were you referring to pain specialists or were you referring to any recommendation of a specialist?

A. Any recommendation of a specialist.

MR. NOLAN: I have no further questions. Thank you.

Before I end, I'd like to move page 309 of P3 into the record.

THE COURT: Any objection?

MS. AGNEW: No.

THE COURT: Received.

(Plaintiffs' Exhibit P3, page 309 received in evidence)

THE COURT: Redirect, please.

REDIRECT EXAMINATION

BY MS. AGNEW:

Q. Ms. Ferguson, you just testified that you didn't intend to discontinue Mr. Dockery's medications forever; correct?
A. That is correct.
Q. How long did you intend for the discontinuation to last?
A. When I learned he was refusing them because of a mouth check, I stated he could have them back (technical interruption) as soon as I learned that, which was not -- which was a day after I discontinued it, and I learned that from legal.
Q. Forgive me, Ms. Ferguson. I think it froze for everyone, not just me. So it's not your fault, it's just the technology.

I asked you how long you intended it to be discontinued, we didn't pick up the answer. So please reanswer.
A. Okay. I said as soon as he agreed to follow the mouth check procedure for the medication, he could have them back. Once I learned that he was refusing them because of the flashlight, or why he was refusing them -- somebody can refuse a medication, any medication and ask for it to be restarted and it will be restarted, any medication, not just in the case of Mr. Dockery.
Q. When did you restart Mr. Dockery's medication?
A. I did not. It was restarted when I was on vacation.
Q. Forgive me. You said you didn't intend for the discontinuation to be forever; correct?

A. Correct.
Q. How did you let Mr. Dockery know if he did the mouth check the way everyone wanted, he'd get them back?
A. Well, number one, I think he knew that, but if he reported that to medical -- I learned about it the day before Christmas break, whenever that was. That afternoon is when it ended up being ordered after I left work, after I told counsel they could be restarted if he would agree to the mouth checks, if he were to tell us that, and they were restarted that evening.
Q. And that evening was December 23rd; correct?
A. I believe so.
Q. Was the court involved in getting Mr. Dockery's medications restarted, to your knowledge?
A. To my knowledge, they were.
Q. Okay. So my question to you is, if you didn't intend the discontinuation to be forever, why hadn't you restarted his medications by December 23rd?
A. Because he never reported to us the things that the court reported to us until the 23rd.
Q. Ma'am, we just read a letter that Mr. Dockery wrote to the nurse administrator on December 8th of 2022.
A. I did not see that letter, so I can't speak to that.
Q. When did you call Aaron Dockery to come and speak with you about the discontinuations of his medication?
A. He refused the medication.

Q. That wasn't my question.

When did you call him down to speak with him --

A. I did not. I did not.

Q. Let's just look again at those documents. I want you to look at Aaron Dockery 310. Can you tell me what that document is?

A. It's a refusal of medication and/or treatment.

Q. And what's the date on that document?

A. 12/1/2022.

Q. And whose handwriting is on that document?

A. Nurse Reilly's.

Q. Where is Mr. Dockery's signature on that document?

A. It's not.

Q. Where is it noted that Mr. Dockery refused to sign the refusal form?

A. It's actually in the AHR note 309, the nurse documented when he refused to sign it.

Q. But isn't she supposed to write "Refused" on the form itself?

A. I don't know.

Q. Tell me something, looking at 309, after the top box, which we've established was written on November 9th of 2022; correct?

A. Yes.

Q. The second box, is that dated November 9th of 2022?

A. Yes.

Q. And that contains nurse Reilly's handwriting, as well, doesn't it?
A. Yes.
Q. And can we agree that that note says: "Telephone order, Brandi Corigliano. Hold Neurontin and baclofen. 830 and 2000 meds. Inmate currently under the influence." Correct?
A. Correct.
Q. Does that say to you that Brandi was called and told that the nursing staff believed that Mr. Dockery was under the influence?
A. Yes.
Q. Looking at the note, did Brandi Lynn Corigliano discontinue Mr. Dockery's medications because the nursing staff believed he was under the influence?
A. She just held them that day, she did not discontinue.
Q. And then the next note, can we agree, is December 1st of 2022; correct?
A. That's correct.
MS. AGNEW: I have no further questions.
MR. NOLAN: I have just a couple of questions on recross.
MS. AGNEW: I didn't move it in. I am so sorry, your Honor.
I'd like to move into the record Aaron Dockery 310.
THE COURT: Any objection, counsel?

MR. NOLAN: No.

THE COURT: Thank you.

(Plaintiffs' Exhibit Aaron Dockery 310 received in evidence)

RECROSS EXAMINATION

BY MR. NOLAN:

Q. Nurse practitioner Ferguson, when you discontinued Mr. Dockery's medications after the refusal on the mouth checks, did you do so because of the MWAP policy?

A. No.

Q. Do you currently follow the MWAP policy?

A. No.

Q. Does anybody in your facility, to your knowledge, follow the MWAP policy?

A. No.

Q. Does anybody in DOCCS, to your knowledge, follow the MWAP policy?

A. No.

Q. Do you need to get RMD approval in order to prescribe an MWAP?

A. No.

Q. When is the last time you actually needed to get RMD approval to prescribe an MWAP?

A. Years.

MR. NOLAN: No further questions. Thank you.

THE COURT: Redirect?

MS. AGNEW: One question.

REDIRECT EXAMINATION

BY MS. AGNEW:

Q. Isn't it true, Ms. Ferguson, that you have needed RMD review and approval for non-formulary drugs?

A. For non-formularies, yes. He asked me about MWAP.

Q. Isn't it true that there are MWAP medications that were deemed non-formulary?

A. Not any that I'm using. Maybe. I mean -- DOCCS has a formulary of every type of medication and then there's some that are non-formulary that we don't use as much.

Q. Do you want to change your answer to the question as to whether or not there has been an RMD review of any MWAP medications?

A. Then I'd have to say I don't know because I don't know.

MS. AGNEW: No further questions.

THE COURT: Anything else?

MR. NOLAN: Nothing further.

THE COURT: Ms. Ferguson, after you discontinued Mr. Dockery's medications, how was it communicated to him that they would be restarted if he complied with the mouth check policy?

THE WITNESS: I don't know.

THE COURT: Anything else, counsel?

MS. AGNEW: No, your Honor.

THE COURT: Thank you. Thank you, Ms. Ferguson.

THE WITNESS: Thank you. can I ask one question?

THE COURT: Yes, ma'am.

THE WITNESS: Are these documents only for me? I'm not to leave them for --

MS. AGNEW: No, you can discard them.

THE WITNESS: Okay.

MS. AGNEW: Thank you very much.

THE WITNESS: Thank you.

THE COURT: Off the record.

(Witness excused)

(Discussion off the record)

(Luncheon recess)

AFTERNOON SESSION

1:51 p.m.

THE COURT: Mr. Wilkerson, would you give your attention to Ms. Phillips, please.

MALI WILKERSON,

called as a witness by the Plaintiffs,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: Please state your name and spell it for the record.

THE WITNESS: It's Mali Wilkerson, spelled M-a-l-i, Wilkerson is W-i-l-k-e-r-s-o-n.

THE COURT: Mr. Morrison.

DIRECT EXAMINATION

BY MR. MORRISON:

Q. Good afternoon, Mr. Wilkerson. How are you feeling?

A. So so, could be better.

Q. How are you currently?

A. I'm about to -- tomorrow is my birthday, so I'll be 49 tomorrow.

Q. Well, happy birthday.

A. Thank you.

Q. What current facility are you housed?

A. Marcy Correctional Facility.

Q. How long have you been in Marcy Correctional Facility?

A. Last year, April some time. April, I believe.

Q. Prior to Marcy, what correctional facility were you housed at?

A. Green Haven Correctional Facility.

Q. How long were you at Green Haven?

A. Since July 2019.

Q. And before Green Haven, what correctional facility were you in?

A. None, I was free at the time. That was the first correctional facility I was taken to after the reception center at Downstate Correctional Facility. I stayed at Downstate for about 10 days for reception and then they send you to Green Haven.

Q. So you got into Downstate in June or July of 2019; is that correct?

A. June it had to be, yeah.

Q. Can you tell the Court a little bit about any medical conditions that you have?

A. I was born with sickle cell anemia, which sprouted a whole lot of other underlying conditions. Because of the sickle cell, it prevents and blocks the blood flow to everywhere. So it causes severe deterioration throughout all of my organs, my bones. So I have avascular necrosis in both hips. I have a lot of abnormalities, I have a lot of kidney problems, liver problems, et cetera, eye problems because of the sickle cell, a lot of it is secondary to the sickle cell.

Q. Go ahead, anything else?
A. That's about it. A lot of other side effects that was caused by the sickle cell.
Q. And you mentioned, and if I heard you right, you were diagnosed with sickle cell anemia when you were young?
A. Yes, I was born with it, yes. When I was about -- when I was able to speak, my mom said it's when I was able to point out I was in a lot of pain, I think a year and a half, two years old.
Q. You said that you're in a lot of pain. Can you describe what that means, what type of pain have you felt throughout your life due to the sickle cell anemia?
A. Well, sporadically, it come at its own control or devices. Sometimes, regardless how well I'm taking care of myself, I go into what's known called sickle cell crisis. That's when it's low blood flow and the hemoglobin, they're not acting right and my blood cells turn into C's. That causes extreme pain throughout my limbs. Sometimes it comes in my legs, sometimes it comes in my back, arms. Wherever it is blood flows, basically I could have a sickle cell crisis and that cases pain. Sometimes I have minor and I just fight them with myself with just pain meds, rest, oxygen, water, whatever, but when it's in a severe crisis, I have to be rushed to the hospital or I risk that.
Q. How old were you when you first remember having a sickle

cell crisis?
A. That I remember, probably around 5, 4 or 5, something around there that I remember going back that far.
Q. What type of treatment have you been prescribed for your sickle cell disease?
A. Over the years, things have changed, medical advances. They first started me on just a daily dose of pain management with Tylenol #3 and Penicillin was the recommended thing when I was young, I'd say maybe between the ages of 2 when I was diagnosed to about 10, along with folic acid. But they stopped the penicillin, they said that wasn't too safe or dangerous or whatever and it weakened my immune system. If I had to get some type of antibiotic, then it would be ineffective, so they stopped that treatment. Then they started giving me hydroxyurea during the process. That didn't go -- I still had -- I think, actually, it caused me to go on a crisis even more --
Q. Let me stop you for a second. What was that medication that you mentioned?
A. Hydroxyurea.
Q. How old were you when you were prescribed that medication?
A. I want to say mid spring, around there.
Q. Is it fair to say from when you were very young, when you were diagnosed until, let's say your 20s, were you being prescribed by a physician Tylenol #3 or some sort of narcotic

medication to treat your sickle cell anemia?
A. Yes. It changed over the years from Tylenol #3 to Norco, to morphine, to OxyContin, what I'm getting now, depending on who was the prescriber and where I was at. Different things changed, different pain management changed.
Q. And were the prescriptions, let's say before you went into custody, these narcotic prescription medications, how were they administered, how often did you take them as prescribed?
A. For the most part, most of the time, they had one long-lasting extended relief, an ER pill. And then they had the Norco, which is also called Lortab. So I would take the Lortab every four hours and the other one was twice a day every 12 hours for continued extended release.
Q. Were these medications taken every day whether or not you were in crisis or only during times that you're in crisis?
A. No, every day.
Q. So just to be clear, whether or not you're -- let's take away the times that you're in crisis, are you still affected by chronic and consistent pain?
A. Yes. And that's due to the deterioration in my bones. I have a spine and back problem. Mostly, once my hips -- my hips started deteriorating and my shoulders started deteriorating, that's when the daily doses really started. Before, when I was a kid, starting around a few years old, I would only take this medication once the sickle cell crisis started acting up and it

was at a low level to try to prevent hospitalization. So once -- if it didn't work, that's when I had to be rushed to the ER and you Demerol was the thing they used in the hospital then, then they went to morphine later on in my life. Now one of the things is Dilaudid that they use once I'm being hospitalized, they use Dilaudid.

Q. Are those IV medications when you're hospitalized?

A. You said -- excuse me?

Q. When you're hospitalized for a crisis, is it IV medications, pain medications that you're provided?

A. Sometime there are injections, but now the Dilaudid most of the time is IV, yes.

Q. How old were you, just to be clear, did you start being prescribed pain medication to be taken every day, whether or not you're in crisis or not?

A. Somewhere in my 20s. Once the hip problem started, I believe -- it had to be sometime after 2002, sometime after 2002, that's when my hips started acting up, somewhere around there, a few years after that maybe.

Q. I noticed you came in on a wheelchair. When did you start using a wheelchair?

A. At the beginning of this incarceration. I was going through problems first inside the county jail where I was at where they didn't -- it was a same, similar situation. They wasn't trying to give anybody any pain medications or whatever.

I went, I was hospitalized. On top of that, they wouldn't give me any kind of bedding, soft cushion bedding. So my hips basically got chipped up even more and messed up even more. And I got -- went to the hospital, Albany Med. And at that point, the specialists and doctors were telling me basically there is nothing they can really do at this point and the best thing to do was to try to sit inside the chair to reduce the pain and curb the damage and deterioration. But I've been wheelchair bound ever since.

Q. When did you become wheelchair bound?

A. I got -- around February 2019, somewhere.

Q. Prior to February of 2019, were you using any other equipment to help you ambulate?

A. Yes, I was using a cane.

Q. And how long were you using a cane?

A. I'd say mid -- around 2005, 6, on and off, getting little flareups or stuff like that. If it's cold or something like that, then it really flares up and messes with me a lot. Some days I have to lay down and just can't get up at all. I was using it on and off for a while and it became more consistent, a daily use, I would say around '11, '12, somewhere around there.

Q. Was it recommended to you by a medical professional that you should use a cane in around 2011 or 2012 or is it something that you did on your own?

A. No, the doctor gave it to me. I believe I was incarcerated at the time and that's when I asked for some type of aid or whatever the case may be, surgeries and try to fix the problem altogether.

Q. So in 2011, 2012, you were incarcerated in a New York State Department of Corrections or somewhere else?

A. Correct, I was -- I got arrested in 2012. By 2013, I was in the Department of Corrections New York State.

Q. For lack of a better term, during that bid from 2013, when did you get out of custody?

A. I believe around 2016, November.

Q. And just to be clear, you then went back into DOCCS custody in June of 2019; is that correct?

A. Correct, yes.

Q. Let's talk about, just briefly about your incarceration in 2013. Do you recall during that time if you were being prescribed any medication for your sickle cell anemia and pain, specifically by a DOCCS medical provider?

A. I believe it was the folic acid, the hydroxyurea around that time and pain management. I'm not sure exactly. I don't recall. I believe I was still on morphine ER around that time.

Q. So there was a point in time that you were being prescribed morphine by a medical provider at DOCCS; is that accurate?

A. Yes, it was a time, yes.

Q. Do you remember during that bid, which you were released in

2016, when you were released, were you being provided morphine?
A. Excuse me. Say that again.
Q. That was a terrible question. I'm sorry.
A. Rephrase.
Q. It's going to happen, Mr. Wilkerson. It's going to happen.
So the incarceration that you were in from 2013 to 2016, when you were released in 2016, was a DOCCS medical professional prescribing you morphine or a pain management medication?
A. After I was released?
Q. No, while you were in, before you were released.
A. Yes, but it wasn't consistently. I had a lot of issues with the doctors and had to have everyone go to Albany with me, file grievances. They finally gave it back to me and when they gave it back to me, they announced that they cutting everybody off. I went back to the doctor again and they had reduced it at first. Then I was letting them know that I'm still in a lot of pain, I can't do it, I can't manage, I can't even think straight. I believe they cut it off still anyway and then gave it back to me after a certain amount of time.
Q. During your 2013 to 2016 incarceration, did you ever have any crises, a sickle cell crisis while you were in custody?
A. All right. Major crisis or random crisis? Because I have random crisis a lot, and those are the ones I don't have to be hospitalized for. So a minor crisis I can get along with the

pain management, rest, plenty of oxygen and water, and the major crisis is when you're near death and you have to be hospitalized. I believe there were -- I can't recall. I'm in and out of the hospital so much. I can't recall exactly when or how many times I was hospitalized or if not, but it's consistent. I'm always, you know, in and out of crisis depending on the situation.

Q. How often do you go into a major crisis, is there some sort of average amount per year, per month?

A. Well, yeah, it used to be an average. I say that because I've learned to take care of myself and as long as I'm being taken care of, I avoid crisis. For instance, I believe May of 2021 was my last major crisis that I had to be hospitalized for, but because I had consistent pain management, I've changed my diet, it's a plant-based diet. I try to do as much as I can proactively. Most of those times when I don't get any help to fight these crises or to calm the minor crisis or whatever, it goes from zero to 100 really, really fast. So on average, when I was younger, it was five times a year for a major crisis and I would say one a month maybe, somewhere around there, all the way into my 20s.

Q. While you're not incarcerated, the times you've not been incarcerated, has there ever been a point in time where your medical provider did not prescribe you pain medication?

A. No, I always been consistently getting pain management in

the free world when I was free.

Q. Did that change at all in regards to when you went into DOCCS custody?

A. Yes. Yes.

Q. Tell me a little bit about that change.

A. Okay. So over the 2013 incarceration, came into the system with pain management, the pain meds. I had my doctor, because they automatically started denying me the pain meds. She advocated for me and wrote letters to the administration to let them know that it could lead to real fatality if I'm not treated properly with my pain management and other sickle cell treatments that I should require. It's Dr. Michelina, who's followed me maybe from 2002, and she unfortunately retired recently. She's been a huge advocate from that point on. So once I got into DOCCS custody, I believe it started when I first came into their custody and that's when they started denying me the meds again. At that point --

Q. Mr. Wilkerson, just to be clear, when you're saying "they," who do you mean?

A. The doctors.

Q. What doctors?

A. I'm not sure all of the names. I know that -- because they keep switching. Like now, I don't even have a doctor, I have a nurse practitioner that fills in for the doctor that quit or resigned or whatever he did. They're just floaters and just do

the paperwork. There's no one that really, you know, is not like my doctor where I'd see him every month, once a month, evaluate me, we'd discuss issues, do my referrals, he was really on top of it. Here, it's a different situation and it's not as thorough as in the streets.

Q. Just to be clear, Mr. Wilkerson, because I think I understand what you're saying, when you're saying "my doctor," are you meaning doctors that you have on the outside?

A. Yes, my primary care physician, which has mostly been Dr. Michelina.

Q. And your primary care physician advocated for you while you were in custody, is that what you were saying?

A. Yes.

Q. Is your understanding she advocated for you to be prescribed pain medication?

A. Yes.

Q. Can you describe to the Court what is the consequences, as you understand it, when you're not being prescribed pain medication or narcotic pain medication, to be specific, for your disease?

A. Physically, I'm in a lot of pain. I can't really move around, care for myself, cook, clean for myself. I can't really function. Mentally, it's a drag, depressing, suicidal ideations at some point in my life. It's really bad, you know, it's not good at all. And I always resent major

hospitalization. That means I'm one step closer to death.
Q. Can you describe to the Court how, if at all, pain medications, narcotic pain medication helps you deal with your disease?
A. Well, it helps me prevent from going into major crisis and it helps me to function a little bit better, a little bit more independently on a daily basis because now I have the daily issues with my limbs and mobility issues and et cetera. On top of that, like, I don't even want to -- I'm really, really cranky. If you see me in pain, some people don't even want to visit me in the hospital, like my mom, my wife. They always -- I'm just in a lot of pain and I'm cranky when I'm in that much pain. I don't mean to do it, but it's just that situation that I'm really tired of. I didn't ask to be born with sickle cell. So I really do be taking it out on the wrong people sometimes. So the pain medicine does help to act the way I should be acting, like to be nice, to be able to function, to be able to think, to be able to go to college. It helped me a lot. So I have my own business and still function. It helped me a lot. Otherwise, I cannot focus, it just throws me all the way off. I'm miserable.
Q. Mr. Wilkerson, do you take narcotic pain medications to get high?
A. No.
Q. Did you ever abuse the prescription pain medications that

you had on the outside to get high?
A. No, never.
Q. How about while you're in custody and you were being prescribed pain medications, did you ever abuse those medications to get high?
A. Nope.
Q. Did you ever sell those medications for money to others?
A. No.
Q. I want to talk about during this recent bid that you had that you came in in 2019. You said in June 2019, you arrived at Downstate Correctional receptions facility; is that accurate?
A. That's correct.
Q. When you arrived at Downstate, do you recall whether or not you were prescribed any pain medication for your sickle cell disease?
A. Yes, I was.
Q. What medication, if you recall?
A. I believe they switched it because they don't give certain pain medicines, they didn't keep the same protocol there. So I believe they switched it to the Xanax (technical interruption) release and the breakthrough one. They changed it to something else, I forget the names of them, but one was an extended release and one was an instant release that was every -- three times a day. Another one was two, two times day.

Q. Were you taking those medications — I think you said you were there for about 10 days at Downstate — every day?
A. Yes.
Q. Is it your understanding that whatever they were — you don't recall the name, that's fine — narcotic medications?
A. Yes. I believe the OxyContin for the extended release and maybe Percocet for the instant.
Q. And then after the 10 days or so that you were in reception at Downstate, you said you were transferred to Green Haven Correctional Facility; correct?
A. That's correct.
Q. And that was around July of 2019, I believe you said?
A. July 1st, I believe it was, or 2nd, 1st or 2nd.
Q. Can you tell me what happened when you transferred to Green Haven on July 1st or 2nd, 2019, concerning your narcotic pain medication.
A. I was housed inside the prison's hospital. They told me I was there to get fitted for a wheelchair and I would be moving on to another facility because I'm classified as a medium status inmate, and it's a max A, the highest classification. So after a while, I want to say a week or so, that's when I believe it was PA Infantino came to me and said, look, we'll put in your medical approvals and if it gets approved -- and they decided -- I don't know who they were. Her higher-ups decided that they was going to taper me off of everything and

that it was not recommended at this time or whatever. And then that's when they started a -- they said it was going to be over 60 days, but it was more like three weeks until everything was just totally discontinued.

At that point, I went through severe withdrawals, a lot of pain, couldn't function, couldn't get out the bed. And they have a crazy rule there that even though you're in the hospital in a hospital bed, in order to get food, you have to come to the dayroom area. At one point, I just couldn't make it, I just didn't -- they just wouldn't bring my food, they wouldn't feed me. That's when I got my people, my family involved, to have my wife start making calls.

Q. When nurse practitioner Infantino informed you that they were going to taper you off or get you off of the narcotic medication, did you explain to her anything about your concern about that?

A. Sure did. She agreed with me that it's crazy. What she was telling me is it's crazy in your condition, like, you know, you got a lot of, you know, pain issues, chronic pain issues. I don't see what's going on or whatever the case may be and I agreed with her. I was like, I'm not going to be able do this, I'm not going to survive. I'm going to be back in the hospital, which I dread because, like I said, each hospitalization is like a chip off of my life clock. I just -- I dread going into the hospitals. I hate it. I've been doing

this since I was 2 years old. And that's -- and that was it. It was left at that. And they just tapered me off and just discontinued it.

Q. After you were tapered off in July of 2019, did you make any complaints or notify anyone within Green Haven Correctional Facility about what was happening with you pain-wise?

A. Yes, I talked to the doctor personally and made complaints, made grievances, wrote sick calls. Like I said, I had my wife contacting the facility and at DOCCS, and she kept getting the runaround whenever she tried to call the central office in Albany, writing her own letters -- yes.

Q. What were the results of the grievances you filed, if you recall?

A. They were denied. They were saying, basically, it's up to the doctors, it's their recommendation and they don't see it's fit or it's not needed, that the pain medicine isn't needed.

Q. After you filed any grievances, were you ever called down to medical to be reevaluated or evaluated about the pain that you were experiencing?

A. No.

However, at one of my appointments with Dr. Silver, who was my PCP, I questioned -- because he said he's putting in another request because he felt it was the same thing, it was ridiculous they would take me off the pain meds. I asked him the reasoning for it or whatever, and this is when he explained

to me that someone had alleged that I was trying to keep medicine when I was in Downstate Correctional Facility. We went back and forth about that, that's not what happened, I explained to him what happened. Once he explained that, that's when I grieved that issue and told him I want that misinformation expunged from my record, that it's prejudicing me and it's causing a lot of problems. Went through that grievance process or whatever, but, of course, they just continued to side all the way up from each level and just didn't make any real, you know, didn't give me the relief that I asked, that it be expunged from my record, because that's not what the nurse wrote, reported. What the nurse wrote, reported was she saw stains on top of my tongue, not that I was cheeking any medication, but that she saw stains on the top of my tongue when she woke me up to give me my medication. And when she came, it's early in the morning, the officer is standing right in front of me, I had a roommate, she came in, a big cup of medications -- I take a lot of medications. I put the meds in my mouth, I went to reach for the cup, the cup was empty. She went and got the water for me, the officer's standing right there, she went and got the water for me, poured it inside a little cup and she came back with the water, poured it inside a little cup, and then I swallowed the pills. When I did the mouth check, whatever the case may be, she said you have stains on your tongue. I said oh, I didn't realize there was still

stains on my tongue or whatever. Okay. So I drunk some more water. She asked to look again, she's like, they're still there. I was like, well, it sat on my tongue for a while, they're like candy coated, you know, I don't know what to tell you or whatever the case may be. She reports it to the doctor. The doctor takes it as that I was cheeking it or whatever, the medication on a higher note, whatever the case may be, which is like 8 to 12 pills at a time and that's how the situation unrolled and unraveled. But they never corrected what the nurse wrote or originally said, which was, you know, stains on his tongue, not that she saw a pill, she saw stains, which is obvious because I was sitting there with a mouthful of pills in my mouth waiting to get water. So I went through these things, so -- and used that as an excuse to discontinue my medication for the longest.

Q. Mr. Wilkerson, you said, and correct me if I'm wrong, that this incident where you were alleged to have been cheeking happened at Downstate?

A. Yes.

Q. And that was in June, around June of 2019?

A. Correct.

No misbehavior report followed or anything like that because, you know, if you are caught in that type of situation, it's required that you get a misbehavior report.

Q. Fair enough.

A. I wasn't in that type of situation.
Q. After this incident, was your medication automatically stopped at Downstate?
A. No, it just -- so that incident happened at the date of my -- when my transfer went in, the day before my transfer went in, and before I even got a chance to really talk to the doctor about it, I was already on the trap and going to Green Haven. So once I got to Green Haven, that's what they saw and then they continued on from there, but that doctor couldn't take me off. It was the medical staff from New Haven that decided to use that as a reason to -- or whoever it was, the higher-ups, yes.
Q. You said there is no misbehavior report or anything written against you for that incident; correct?
A. That's correct.
Q. So there is no formal way or process for you to challenge what was written by the nurse in your AHR; is that fair to say?
A. No, it's not fair to say. I grieved. I put in a grievance and I asked them to correct the information, rely on whatever she wrote in her reports, question her, call her as a witness, and she'll verify that it wasn't that situation, that it was a stain, a different colored stained on my tongue.
Q. Was there a hearing on the grievance?
A. Yes, at the lower level. The upper levels there aren't any hearings, it's just the IGRC hearing, the Inmate Grievance

Resolution Committee hearing by the committee, and it's a sergeant and another staff member. They agreed on that level that it should be ruled in my favor, but once we got to the superintendent's level and in the CURC, they denied my grievance.

Q. Just, again, to be clear, when you got to Green Haven, you're in the infirmary and the doctor was trying to prescribe you that medication; is that correct?

A. Yes, Dr. Silver. That's what he told me, he said he was putting another request, he's, you know, doing it, but they keep getting denied by his bosses, his supervisors and his superiors.

Q. Just because I'm a little confused. If I remember your testimony correctly, when you got to Green Haven, you were in the infirmary and you were being treated by nurse practitioner Infantino?

A. Correct.

Q. And it was Infantino who first told you that you weren't going to be prescribed your medication?

A. Yes, that it was going to be tapered and that she put in her original request, the MWAP reform request and it was denied and suggested that the (technical interruption) discontinued with the tapering of the -- 60 days in total, 30 with one and then finally -- but it was a whole lot quicker process. And they just --

Q. So how long after this meeting with nurse practitioner Infantino, when you first arrived to Green Haven, to the discussion with Dr. Silver when he said he was trying to put in another request for the medication, if you recall?

A. Oh, this had to be well over three months, I would say, around that time, because that's one of my complaints, that I didn't see a primary care physician, didn't have anyone to follow up, getting all these other assessments and appointments done for me. On any of my other issues, my sickle cell retinopathy for my eyes and -- I needed to see a doctor or whatever.

So, I actually went out, I believe, to a hematologist, a specialist, Dr. Asif, and once I got back, that's when I explained to the nurse that I had never seen a doctor. She was, you know, kind of bugged out about it. And she said okay, I'm going to put you in right now because that's ridiculous that you haven't seen a doctor and you've been here for so long.

Q. So it was this first time that you actually saw your provider months after you arrived at Green Haven that Dr. Silver said he's going to try to put in another request for your narcotic pain medication; correct?

A. Yes.

Q. Is it your understanding that that request was denied?

A. Yes.

Q. How long were you at Green Haven, being deprived of narcotic pain medication to treat your sickle cell?

A. Too long. I believe it was all the way to 2021 after I obtained the help of Ms. Agnew, my counselor, that she started making some arrangements and we started getting some headway on getting reevaluations. And I was sent to -- I believe it was Fishkill -- no. I think it was in Coxsackie RMU, over there. I was reevaluated by the pain management specialists. After that is when they tried to start giving me other medications.

The first medications they gave me, I always had a problem with, even in my last incarceration, because I have an allergic reaction to it, gabapentin. So they gave me -- they still gave me gabapentin, and I was really sick, my stomach was crazy, diarrhea, throwing up, I couldn't stomach it, keep it down or whatever.

Shortly after that, I went to sick call and the nurse informed me, she was like, well, how's the other pain medicine going for you. I was like, what other pain medicine. That's when she told me that the other OxyContin had already started and I was supposed to have been got it already, nobody ever informed me. So after that, that's when I started reporting down there and she made sure I could come down there on a daily basis to get it twice a day.

Q. That was at Green Haven or Coxsackie RMU?

A. No, that was at Green Haven. The RMU, because I go to a

couple of them, that's where they have their little meetings sent up with certain specialists. But I believe that was where the assessment, the pain management assessment was. It was at Green Haven that they actually did the -- that they started giving me the pain medicine, first the gabapentin that I wasn't supposed to get again because it makes me sick, then I got the OxyContin.

Q. What effects, if any, did your prescription of OxyContin have for you in 2021 when it was prescribed?

A. It relieved a lot of my pain, especially because, with me, I know how this opiate thing works, so I try to maintain the lowest possible dose possible. I asked for permission from Dr. Silver that, at those times, instead of increasing -- and this is why I maintain the lowest level possible of 15 milligrams. Instead of increasing, to just give me a day, maybe a day or two reset where I could just -- before I go into detox, full detox, I just stay there. But that medicine, that's been managing my pain ever since, you know, very good.

I have recently had some instances with standing outside in the cold here, med lines, you know, a mile away and they have you travel or whatever. That's been exacerbating my pain a lot, but it's hard to see a doctor there. If I don't go to the doctor, I have to go to the practitioner for Percocets. So I didn't to try even see her to talk to her about decreasing or whatever.

But, for the most part, I've been maintaining, I haven't been hospitalized, I haven't gone into major crisis, minor ones, yes, that's inevitable, but I know with my age and my wisdom, I know how to catch that now, I know how to, you know, lay down and drink and overfluid, you know, rinse myself out and fight those. I've been pretty -- thank God, I've been pretty successful at fighting hospitalizations with this pain management.

Q. That period of time when you were discontinued and not provided narcotic pain medication while you were at Green Haven, do you have an idea or some sort of feeling about whether that has affected you in any way or deteriorated yourself in any way?

I'm sorry. That's a terrible question, but if you understand it.

A. Yeah. Yeah. Yes. Yes. Like I said, my sleeping, my eating, my mental state, everything depreciates along with this pain level. The higher the pain level, the less I want to do, the less I can do. I can take some short steps now. Once the pain management started, I'd be able to, you know, lay down and do some type of physical therapy for myself. They supposed to give it to me, but I never made it there. So I've been a little bit more able to be more proactive and do what I can for myself, it does make a big difference, and those times that I don't have it, I deteriorate quick, very fast. When I first

got to Marcy, just in that week's time, I lost a lot of weight. I suffered and went through a lot of pain and, you know, because they -- as soon as I got here, they said this is just not a jail we do that in. I started to explain, like, look, I've been fighting tooth and nail, you know, just to get some help, and I finally got it and I need it bad. They said sorry, we don't do that here.

Q. Let me stop you for a second, Mr. Wilkerson, because that's actually where I wanted to address and direct your attention to.

You said you arrived in Marcy in around April of 2022?

A. Yes.

Q. When you came to Marcy from Green Haven, were you prescribed OxyContin at Green Haven?

A. Yes.

Q. What happened when you were transferred to Marcy with your medication?

A. They transferred me and another individual in a wheelchair, they brought us over. We went to the draft room and they told me I had to be seen by the nurse. The nurse gave us the spiel about how sick call works here and what days are what. Then she said I also must inform you that this is a facility that we don't give out pain meds here. I was like, why not? The policy changed, we got a new policy now that we've been fighting for for years or whatever, like, I don't understand.

She's like, I'm sorry, it just doesn't -- she's like, I'm going to put you in to see the doctor immediately because I know, in your condition, with sickle cell and necrosis, you're in a lot of pain, and see what happens from there or whatever, but I'm going to let you know it's not worth it to fight because it just doesn't happen here.

Q. Were you weaned off the medication or was it just stopped?

A. It was just stopped. Just stopped.

Q. How long after you saw this nurse upon your arrival did you meet with a doctor?

A. About a day or two. Dr. Burke.

Q. Describe to me that interaction you had with Dr. Burke.

A. He was also a surprise, too, in saying that, you know, his hands are tied because this is how DOCCS does things and, you know, he can't really -- if I was in his private practice in the streets, automatically, I would get the pain meds because my conditions, you know, call for it, it's textbook stuff.

He said as soon as I get home, I need to look into doing the hip surgery. He showed me his scars from his hip surgery and said, you know, look, I'll dance around, you know, I'm much better. I had my concerns about the hip surgery and stuff because I have a twin brother and his didn't -- he had one of those types of hips (technical interruption) and it was bad, like hip surgery after hip surgery. I told him I was kind of nervous. He said it's a (technical interruption) surgery.

He told me about that, showed me his scars, jumped around. He said, you know, it's nothing you can do about it or whatever the case may be. So then I said all right, I need (technical interruption) we'll figure this out or whatever the case may be. But I didn't mention anything about the class action that's going on. I said I'll figure it out. I asked him for some other -- like ibuprofen or something else to help me to at least ease the pain. He prescribed me the ibuprofen, which I had to stop taking because I have a lot of (technical interruption) issues. So I had to stop taking them because that was the only thing they was trying to substitute once they took me off throughout this incarceration.

Q. Let me stop you, Mr. Wilkerson.

When you met with Dr. Burke, did you agree to discontinue your medication?

A. No, absolutely not.

Q. Did you ask Dr. Burke to be prescribed the OxyContin and the pain medication?

A. Yes, and he said his hands was tied, it's not up to him and it's just a situation that he can't do because it's not up to him.

Q. How long were you deprived of that medication after you arrived at Marcy in April 2022, if you recall?

A. A week and a couple days.

Q. What is your understanding why or how that medication was

provided to you again?
A. I called my attorney. I had my wife contact my attorney, let her know it was an emergency, that I was already feeling like I was ready to go into crisis. My wife explained what they did, that they just stopped the pain medicine or whatever the case may be. Ms. Agnew told her to sit tight, she's going to do what she can. The next thing you know, they called me down and said -- it was an evening, I believe like a Thursday or a Friday evening, and they said, here you go, good job, because nobody else getting it, like, they said here you go, good job.
Q. And your medication was he instated?
A. Yes.
Q. Are you concerned that if you get transferred to another facility that this same situation could occur again?
A. Very. It only happened once, it's bound to happen again.

But when I had the conversation with Dr. Burke and I explained to him, you know, this is ridiculous because the MWAP policy is supposed to changed, it's not effective, he looked at me like I had two heads, like he didn't know about any policy change. As far as he know he had to fill in all of this paperwork to get approvals from higher up.

MR. NOLAN: Your Honor, I'm going to object to the testimony to the extent it's offered for truth of the assertions from Dr. Burke to him, understanding that they're

offering it for perhaps what the conversation was, the fact that he said it.

THE COURT: You're offering it for the fact he said it, aren't you, counsel?

MR. MORRISON: Correct.

MR. NOLAN: As long as it's limited to that, your Honor.

MR. MORRISON: Mr. Wilkerson, I have no further questions. Thank you very much.

THE COURT: Cross examination, please, counsel.

MR. NOLAN: Can we take five to ten minutes, your Honor.

THE COURT: We're going to take a little break, Mr. Wilkerson. We'll see you in about five minutes.

THE WITNESS: It's okay. I can run to the bathroom.

THE COURT: What are you thinking for cross, counsel?

MR. NOLAN: Probably 10 to 15 minutes.

THE COURT: How long will the next witness be, please, friends?

MS. AGNEW: Probably the same. Actually a little shorter. Mr. Johnson is of shorter thought streams.

(Recess)

THE COURT: Shall we cross?

MR. NOLAN: I'm just waiting for one second. My colleague is going to grab a piece of paper for me and I'll be

right up.

THE COURT: Yes, sir. You ready to go?

MR. NOLAN: Yes.

THE COURT: Cross examination of Mr. Wilkerson, please.

CROSS-EXAMINATION

BY MR. NOLAN:

Q. Good afternoon, Mr. Wilkerson. Can you hear me?

A. Yes, sir.

Q. You mentioned earlier that someone told you upon arrival to a facility in 2022, I think it was, that we don't give that out here, meaning a specific medication; correct?

A. Yes.

Q. Can you identify who that was for me?

A. It's been a while. I'm not sure which nurse it was. It was a nurse that did the screening that does all of the intakes, the draft intakes. I'm not sure who that was.

Q. Was it a nurse practitioner, if you know?

A. No, it was just a regular nurse. I believe she was -- I'm not sure. I'm not sure.

Q. Was it somebody, to your knowledge, who was in a position to prescribe medication?

A. That I'm not sure of either.

Q. When the unidentified nurse told you that, did she mention the word "MWAP" or "MWAP policy"?

A. No.
Q. Did she say why they don't give it out?
A. No. She just said we don't give it out here at this jail.
Q. What drugs are you on right now today, what prescriptions do you have?
A. I'm on folic acid, I have a stool softener, Omega-3 oils, a multivitamin for minerals, the OxyContin 15 milligrams, Claritin. Did I say folic acid already? Probably. Long list, pretty long list. And the ibuprofen and Tylenol.
Q. You mentioned the OxyContin, which sounds like the one that's probably most effective for your pain; is that right?
A. Yes.
Q. Are you on that today?
A. Yes.
Q. And how long have you had continuous access to OxyContin until today?
A. Up until after they gave it back to me here on arrival, a week after I arrived here.
Q. Can you tell me, to the best of your ability, when exactly you think you arrived at that facility you're at now?
A. About around April of last year, 2022.
Q. Do you recall a conversation with one of your providers where you discussed your ongoing use of OxyContin with her and the risks of addiction, did you have that discussion?
A. With one of my providers?

Q. Yes, in May of 2022.
A. In May of 2022?
Q. Yes.
A. No. Well, I've always expressed that I don't want to be on higher doses because I don't want to be too dependent on them or have to be taken off where the withdrawals are too strong. The stronger the medication, the stronger the dose, the stronger the withdrawals. On top of that, that means I go into sickle cell crisis along with the withdrawal. Those are the type of things I discuss with them.
Q. Are there times when you advised your healthcare providers, since May of 2022, that you would like to stay off it to the extent possible? And by that I mean OxyContin.
A. No, and I know I have to have it. If it was an option, no, I wouldn't want to take it at all.
Q. When are you scheduled to be released from prison?
A. February 16th, next week.
Q. So when you said you were worried about being transferred in the future, you meant between now and February 16th, you're worried about losing your OxyContin?
A. Well, if there is a transfer between then, which I highly doubt because I'm on my way out now, yes, I would be worried.
Q. But barring a transfer between now and then, you have no reason to worry about losing your OxyContin that you're aware of; is that fair?

A. It's not a reason right now, no.

MR. NOLAN: Thank you for your time. Appreciate it.

THE WITNESS: No problem.

THE COURT: Redirect, please?

MR. MORRISON: Nothing further.

(Witness excused)

MS. AGNEW: Your Honor, should we talk about scheduling?

THE COURT: Do you want to be on the record?

MS. AGNEW: Sure.

THE COURT: Yes, ma'am.

MS. AGNEW: So, plaintiffs are actually going to rest at the close of tomorrow. I wanted to let defense counsel know that so they can line up their rebuttal witnesses for Thursday, if any.

THE COURT: Do we have anything in mind yet, friends?

MR. NOLAN: I don't know exactly who she has scheduled for tomorrow to know about our rebuttal witnesses.

THE COURT: It's going to be more of the same probably.

Do you have anyone in mind yet?

MR. NOLAN: Yes.

THE COURT: How long?

MR. NOLAN: Not long at all. Probably half hour for each.

THE COURT: For each? How many?

MR. NOLAN: However many we need. I don't think it's more than two.

MS. AGNEW: Just so you know, tomorrow is going to be a gentleman from Eastern and then the gentleman from Shawangunk, then Dr. Win.

THE COURT: We have Mr. Johnson.

Mr. Johnson, may I ask you to give your attention to Ms. Phillips and raise your right hand, please, sir.

CLAUDIO JOHNSON,

called as a witness by the Plaintiffs,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: Please state your name and spell it for the record.

THE WITNESS: Claudio Johnson, C-l-a-u-d-i-o J-o-h-n-s-o-n.

THE COURT: Ms. Agnew.

DIRECT EXAMINATION

BY MS. AGNEW:

Q. Good afternoon, Mr. Johnson.

A. Good afternoon.

Q. Could you please tell the Court how old are you?

A. 61.

Q. And how long have you been incarcerated on this bid?

A. Since 2009.

Q. Do you have any prior bids before this one?
A. Yes, ma'am.
Q. How many, sir?
A. I'm ashamed to say four move before this.
Q. So when this bid started in 2009, did you have any major health issues that you recall?
A. Yes, just my spine with a PITUITARY tumor, asthma.
Q. So did you know that you had a pituitary tumor before you started your bid in 2009?
A. Yes.
Q. And can you describe for us what your spinal issues were around 2009.
A. Around 2009, I was getting a lot of pain, I wasn't able to stand straight, pain shooting down my leg, shooting down my hip.
Q. How had you had any surgeries before 2009?
A. Yes, ma'am.
Q. And what surgeries have you had?
A. It was just the one surgery when they removed a bullet --
Q. And when did that occur?
A. -- from my spine.

Back in 1990.

THE COURT: I'm sorry, Mr. Johnson. Did you say from where the bullet was removed?

THE WITNESS: Excuse me?

THE COURT: Where was the bullet removed from, please?

THE WITNESS: Where?

THE COURT: Yes, sir.

THE WITNESS: From my lower spine.

THE COURT: Thank you.

Q. And is it your understanding that the bullet was the source of your pain in your spine?

A. Yes, ma'am.

Q. So can you generally describe your medical history from 2009 to present. I think what we should do is talk about your major surgeries briefly so that the Court is aware. Okay?

A. Okay. Okay, we're going to start with the gunshot wound. I was shot in my lower spine and I had the surgery for that. I do have bullet fragments and bone fragments back there. I had two fusions because one of the fusions popped out and I had to get another surgery and get another one put in.

Q. Let's slow down. Where were the fusions done?

A. When?

Q. What was fused?

A. My S1 to my L4.

Q. And so that's in your back; correct?

A. Yes, ma'am.

Q. Do you recall approximately when that fusion took place?

A. Let me look at my notes. Can you give me a minute, please.

Q. You can refresh your recollection, but I don't want you to

read from them. Just look at them to refresh.

Mr. Johnson, let's do this, I don't want you to get rattled. Can you look up again?

A. Yes.

Q. Have you ever suffered from a stroke?

A. Yes.

Q. Do you remember when that happened, approximately?

A. I think that was like 2010, 2011.

Q. After that happened, did you spend time in a regional medical unit?

A. Yes, ma'am.

Q. Did you completely heal after that stroke?

A. No, ma'am. I still have slight weakness in my left leg.

Q. Did there come a time after 2011 when you had a brain surgery?

A. Yes, ma'am.

Q. Do you recall what the brain surgery was addressing?

A. It was a pituitary surgery. I got it removed twice, if I could recall. The third time was gamma knife.

Q. Do you have an understanding of what had to be removed from your pituitary gland?

A. Yes, ma'am.

Q. What was removed?

A. It was a tumor that was pressing against my brain that could affect my vision, my thyroid, my male hormones.

THE COURT: May I interrupt for a moment.

Mr. Johnson, did you say the third time was a gamma knife?

THE WITNESS: Yes, ma'am.

THE COURT: Thank you.

Q. Can you tell the Court what that means, how is that different than what happened before?

A. Gamma knife is a new -- it's something new that they do where they attach some helmet to my head and screw it in. Then they take a picture of the pituitary tumor and stick my head into a machine and they zap the tumor and hit it with radiation. It's supposed to kill the cells inside the pituitary tumor, it stops it from growing.

Q. The pituitary surgeries and the gamma knife procedure, have those been successful in eradicating your pituitary issues?

A. Well, ever since the gamma knife, it had stopped growing. They said it's stable. I still get headaches, not as much.

Q. When you do get headaches, how do those affect you, Mr. Johnson?

A. It's the kind of migraines where the light bothers my eyes, makes me feel nauseous.

Q. When you suffer from those migraines, does it affect your daily living?

A. Yes, ma'am.

Q. Is it a negative effect or a positive effect?

A. Negative.
Q. How does it affect your daily living when you have those migraines?
A. When I sleep in the bed, I put something over my eyes to just make everything look black, just lay in my bed, don't move.
Q. Other than the migraines, let's just say since 2017, have you suffered from chronic pain?
A. Yes.
Q. Where do you suffer from chronic pain in your body?
A. In my lower back.
Q. And do you believe that to be from the bullet wound?
A. Yes, ma'am.
Q. After you had the fusion, did that chronic pain improve in your lower back?
A. No, ma'am.
Q. So what I want to know is, there was a period of time when you stayed at the Walsh Regional Medical Unit. Do you remember that?
A. Yes, ma'am.
Q. Can you tell me what procedures you had when you were at Walsh?
A. When I was at Walsh, that's when I believe I got the pituitary tumor removed.
Q. Did you also get a back surgery when you were at Walsh?

A. Yes, I did get the back surgery done, too, twice.
Q. After the surgeries took place, were you treated with any medications for your chronic pain?
A. Yes.
Q. Which medications, Mr. Johnson?
A. I was on Neurontin, I was on morphine, I was on Percocet.
Q. Do you remember who your doctor was at Walsh?
A. I can't remember his name.
Q. Would it refresh your recollection if I said Dr. Michael Salvana?
A. Yes.
Q. Did there come a time when you left Walsh and you were transferred somewhere else?
A. When I left Walsh -- where did I go when I leave Walsh? I went back to Green Haven.
Q. When you went to Green Haven from Walsh, do you remember approximately what year it was?
A. No, I really don't. I can't remember.
Q. Was it after 2017?
A. No.
Q. When you went from Walsh to Green Haven, were you able to continue taking your chronic pain medications?
A. No.
Q. Do you recall what happened?
A. Yeah, they discontinued all my meds. They just gave to me

for like -- for a short period of time and took me off everything.

Q. Did you have any conversations with anyone about why you were taken off your medications?

A. No.

Q. Did you bring it up with anyone as to why you were taken off your medications?

A. Yes. Dr. Kournikova.

Q. Do you remember the substance of your conversations with Dr. Kournikova?

A. She just said that she wasn't given me my pain medication back, she was just given me, if I'm not mistaken, Tylenol.

Q. What was the effect on your chronic pain when you stopped getting your pain medications?

A. Severe, I mean excruciating.

Q. Explain to the Court how you felt in the time afterward when you weren't getting medications for your chronic pain?

A. It was hard for me to get out the bed, go to the bathroom. It was hard for me to do daily activities, period.

Q. Did it affect how you were able to ambulate around Green Haven?

A. Yes, ma'am.

Q. How so, sir?

A. I mean, I couldn't even function. I mean, I would get angry at my family. It was frustrating.

Q. Can you tell me, did there come a point in time when you got your medications back?
A. What they was doing was, they would give it to me for a couple of days and then take me off of it.
Q. Who would put you on it for a couple of days and take you off?
A. It would have -- I forgot the name of the doctor, but he would do it when Ms. Kournikova wasn't there.
Q. So it was a doctor at Green Haven?
A. Yes, ma'am.
Q. Would he check you into the infirmary when he would give you the medications for a few days?
A. Yes, ma'am.
Q. And then when you got checked out of the infirmary, did you still take them?
A. No, ma'am.
Q. So did there come a point in time when you and I met each other?
A. Yes.
Q. After you and I met each other, did your medications get reinstated by DOCCS at some point?
A. No.
Q. Are you taking anything for your chronic pain now, Mr. Johnson?
A. Yes, I'm taking Neurontin and -- what's the name of it --

Celebrex.

Q. Since you started Neurontin and Celebrex again, has that helped you with your chronic pain?

A. A little bit.

Q. Better or worse than when you weren't on them?

A. 1 out of 10, I give it like a 4.

Q. Is there something you feel that you could take that would help more?

A. What I was taking in Green Haven when I was on my morphine and my Neurontin. I was able to function, I was able to stand up straight instead of crouched down like I'm an old man.

Q. Do you remember, last year, getting transferred to Woodbourne?

A. Yes, ma'am.

Q. Do you remember if anything happened to your pain medications when you got transferred to Woodbourne?

A. Yes. When I got to Woodbourne last year, they didn't give me the medications that I was getting here in Marcy because she said we don't give those medications out here, we don't give the Neurontin out in Woodbourne.

Q. Do you recall who told you we don't give those medications here at Woodbourne?

A. Yes, Dr. Ruiz.

Q. How long after you got to Woodbourne did you sit down with Dr. Ruiz?

A. I saw her maybe two weeks after I got there, maybe.
Q. Did you receive your Neurontin between the time you arrived and the time you sat down with Dr. Ruiz?
A. Not at all.
Q. Did you speak with anyone when you got to Woodbourne and you weren't getting your medications, besides Dr. Ruiz?
A. Yes.
Q. Who did you speak with?
A. I grieved it because she didn't want to give it to me. I signed up for sick call and went back to see her and told her how I'm going to need my pain meds. She said she is not giving me my pain meds. She said I could write Albany and tell them that she's not going to give me my pain meds. I told her I wasn't going to write Albany, I was going to write my attorney. She said, well, make sure you spell my name right.
Q. Did there come a time when Dr. Ruiz re-prescribed you your pain medications?
A. No.
Q. Mr. Johnson, when you went to Woodbourne, do you remember being on a blood thinner?
A. Yes.
Q. Did Dr. Ruiz talk to you at all about your blood thinner?
A. No, she didn't. But, what I found out was that when I came back to Marcy, that the milligrams that she had me on was wrong.

Q. Let's back up. How did you come back to Marcy, do you have an understanding of how you went back to Marcy?
A. Yes. I couldn't take the pain and I called you.
Q. And then what happened?
A. You did what you did and got me back to Marcy.
MS. AGNEW: All right, Mr. Johnson. I have no further questions for you. Another gentleman, he's going to get to ask you questions. All right?
THE WITNESS: Yes, ma'am.
THE COURT: Thank you. Cross examination, counsel.
CROSS-EXAMINATION
BY MR. NOLAN:
Q. Good afternoon, Mr. Johnson. Can you hear me?
A. Yes, sir.
Q. I have just a few questions for you.
Can you clarify what medications you're on right now?
A. Right now, I'm on -- as far as self-carry or when I go to the clinic?
Q. Let's do both, let's start with self-carry, you can tell me that, and then we'll do the clinic. Okay?
A. Where do I start? Self-carry, I take Metformin -- I take like 13 different medications, sir. Metformin, Lipitor, Claritin, iron pills, vitamin D -- what else do I take?
Q. Let me ask it this way, for the self-carry ones, do you have any that are addressed to pain?

A. Excuse me?
Q. For self-carry, are any of those for pain, say ibuprofen, Tylenol, anything like that?
A. Oh, I take Topamax and Keppra.
Q. Are Topamax and Keppra self-carry?
A. Yes, sir.
Q. How many milligrams of Topamax?
A. Topamax I think is 100.
Q. What about Keppra?
A. Keppra is 500.
Q. And the Topamax, what do you take that for?
A. Supposed to be for headaches.
Q. How about the Keppra?
A. Supposed to be for seizures, headaches.
Q. So as far as you know, you're on about 13 self-carry medications, and at least two of those are for pain; right?
A. Yes, for headaches.
Q. How about the other ones, I guess what we would call the one-to-one medications, what are you on for that?
A. The ones I go to the clinic to take?
Q. Those, yes.
A. Coumadin, Celebrex, and Neurontin.
Q. If you know, what do you take the Coumadin for?
A. Coumadin is for my back pain.
Q. And the Celebrex, what do you take that for?

A. It's for my back pain.
Q. And how about the Neurontin, back pain?
A. Back pain. The Coumadin is for blood thinners. I'm sorry.
Q. That's okay. So Celebrex and Neurontin for back pain and the Coumadin for blood thinners; right?
A. Yes.
Q. What is your current dose of Neurontin?
A. I think it's 500.
Q. Since you've been on Neurontin, since the last time it got prescribed to you, has it always been 500?
A. No, it was raised a little bit.
Q. When was it raised?
A. Couple of months ago maybe.
Q. Do you know which provider raised it for you?
A. I don't know her name. It starts with a C. She's a PA.
Q. Would it be nurse practitioner Corigliano?
A. Yeah. Yes, sir.
Q. You have a pretty good relationship with her?
A. I don't have a bad relationship with anybody, sir.
Q. How long until you believe you're going to be released from prison, sir?
A. Five months.
Q. Would that put us into July?
A. August.
Q. When Dr. Ruiz -- it sounded like you testified that

Dr. Ruiz didn't want to prescribe you morphine; is that fair?
A. Doctor who?
Q. I believe you said Ruiz?
A. Ruiz.
Q. She didn't want to prescribe you morphine. Was that your testimony?
MS. AGNEW: Objection, your Honor.
THE COURT: Sustained.
A. No, she didn't want to prescribe me Neurontin.
Q. Neurontin. That's why I asked if it was your testimony.
So when was that that Dr. Ruiz didn't want to prescribe you Neurontin?
A. Last year.
Q. Do you remember when last year?
A. I can't recall. Give me a second.
Q. It's okay. You don't need to look at anything. It's not that important.
How about I ask you this way, just to clarify for the record, looking backwards from today, how long have you had a prescription for Neurontin?
A. How long?
Q. Yeah.
A. When the procedures changed.
Q. I'm sorry, I didn't quite catch what you said, sir.
A. I said when the procedures changed, Dr. Zaki gave me a

script for Neurontin -- I'm just --

MS. AGNEW: Counsel, I'd ask him to look up again.

Q. Before you do anything, sir, are you looking at some documents?

A. Yes, I am.

Q. Can you identify what those are for us for the record.

A. It's just when I was prescribed meds and stuff like that, the dates. That's all.

Q. When you say the dates, can you hold up the document you're looking at, sir.

Have you been looking at that document this whole time, sir?

A. No.

Q. What is that document titled?

A. There's no title on it.

Q. What does it say at the top?

A. Claudio Johnson.

Q. Who sent you that document?

A. This is my document.

Q. How did you get it to where you are today?

A. I brought it with me.

Q. Did anybody tell you to bring that with you?

A. No.

Q. Were you looking at that document in preparation for your testimony today?

A. Yes, because I'm bad with dates.
Q. Who drafted that document?
A. I did.
Q. Can you hold it up again. Closer to the camera, please. Back a little bit. Hold it up, because we need to understand what you're looking at, and bring it forward slowly.
Okay. You typed that up yourself physically?
A. Yes, I did. I went over to the library and typed it up.
Q. So those are your notes that you studied in preparation for your testimony today; is that a fair way to say it?
A. Yes, sir.
Q. What did you use to prepare those notes?
A. Notes that I've been sent by my attorney and I put them all together.
Q. So your attorney sent you notes and then you took notes from that?
A. Yes.
Q. And then you testified from those notes today?
A. No, I read them last night.
Q. So what you're testifying to today is based on what your attorney told you; is that fair?
A. No, she didn't tell me anything.
Q. It's based on what your attorney wrote to you; is that fair?
A. You could say that.

Q. When Dr. Ruiz told you she was not going to prescribe you Neurontin, did she tell you why?
A. She said because they don't get those medications out here in the jail.
Q. When she said "they," do you know who she was referring to?
A. She said we don't give out these medications out here.
Q. Was she referring to herself in the "we," if you know?
A. I don't know what she meant by that. She said Neurontin is not given out in this jail, in Woodbourne. Whatever she meant by that, I didn't get my medication.
Q. Did she mention anything with regard to the term MWAP when she said that?
A. In term of what?
Q. MWAP.
A. No.

MR. NOLAN: One second?

THE COURT: Yes, sir.

MR. NOLAN: Your Honor, I don't have any further questions.

I do have an administrative issue here.

THE COURT: Why don't we see if we have any redirect.

MR. NOLAN: It does have to do with his testimony.

THE COURT: What do you want to know?

MR. NOLAN: I would move to strike his entire testimony because it was based on a document sent to him by his

attorney that's not in evidence today. He was reading from it, it wasn't used in a way to refresh his recollection properly. It seems entirely inappropriate, your Honor.

THE COURT: Ms. Agnew.

MS. AGNEW: Your Honor, I asked him just to look at the document to refresh his recollection if he needed that, he said that's what he did. In fact, I asked him to look up at me while he testified for just that reason. Mr. Johnson did so, I think to the best of his ability. In fact, the longest period of time he's been looking at the document is when my counsel allowed him to do so for a long period of time.

MR. NOLAN: Your Honor, I'll just represent that what I saw was the summary of the medical records prepared by Ms. Agnew's office. It looked like what was in the Carinci report. It doesn't look like anything that this gentleman prepared himself. I can't see it right here and it was unclear on the screen, but it certainly wasn't evidence.

THE COURT: Anything else?

MS. AGNEW: He's allowed to use anything to refresh his recollection that helps him.

MR. NOLAN: That's actually not true, unless he's having trouble recalling and meeting certain thresholds, that's obvious.

THE COURT: Anything else?

MS. AGNEW: I think he had trouble recalling, your

Honor. I think that's why counsel allowed me to lead as much as he did, which I do appreciate given the circumstances of this witness.

THE COURT: Anything else?

MR. NOLAN: That's all, your Honor.

THE COURT: Two things. Number one, he was instructed only to look at the documents to refresh his recollection. Number two, my observation of him was that he was not looking down at it much at all until defense counsel told him to look at it and examined him about the document. So I will permit it and the motion to strike is denied.

Redirect. Please, counsel.

REDIRECT EXAMINATION

BY MS. AGNEW:

Q. Mr. Johnson, can you see me?

A. Yes, ma'am.

Q. Very good. Just a couple questions.

A. I put the documents down.

Q. I appreciate that. Don't worry about the document and let's not look at it anymore. Okay?

A. Okay.

Q. Mr. Nolan asked you about when Brandi Lynn Corigliano increased your Neurontin; correct?

A. Yes.

Q. Do you remember who visited you right before she increased

your Neurontin?
A. You did.
Q. Can you please tell the Court what happened after I visited you with Brandi Lynn Corigliano?
A. Well, when you came to visit, right after you left, they took my double mattress. As a matter of fact, right after you left, they took everybody's double mattress. A whole lot of weird stuff started happening at the facility as far as medical-wise. I got -- well, she did add my Celebrex.
Q. But do you remember the interaction you had with Ms. Corigliano after I visited you?
A. Oh, yeah. Oh, oh, oh, yeah. She called me into her office and -- I didn't put in for sick call or anything, she just called me down and asked me to have a seat. So I asked her what is it about, and she said listen, I know your name is filed with this lawsuit. I said excuse me? She said, I know your name is on a list of the lawsuit. I said how did you know this, how do you know this, and she wouldn't answer my question. She said I just want you to know we start from scratch, whenever you need something, all you have to do is ask. I said wait a minute, how do you know my name is on this lawsuit, and she said we're starting off fresh as of right now.
Q. After that, isn't it true Ms. Corigliano increased your Neurontin?
A. Yes, ma'am.

MR. NOLAN: Objection.

THE COURT: Mr. Johnson, at the end of your last answer, you said, "I said wait a minute, how do you know my name is on the lawsuit." Then you said, "she said, 'something, something, something'" right now, and I missed it. Could you repeat that for me?

THE WITNESS: Yes, your Honor. She said -- I said how do you know my name is on the lawsuit and she wouldn't answer me. She said as of right now, we're starting from scratch, you want to erase, you know, in other words she's telling me as of right now, it's a clean slate. I asked her again, how do you know my name is on this lawsuit, she wouldn't answer me.

THE COURT: Thank you.

MS. AGNEW: No further questions, Mr. Johnson. Thank you.

THE WITNESS: Thank you, Ms. Agnew.

THE COURT: Mr. Nolan, recross?

MR. NOLAN: No, your Honor.

THE COURT: Thank you, Mr. Johnson.

MS. AGNEW: We're going to see you in a couple weeks, Mr. Johnson. Okay?

THE WITNESS: Okay.

THE COURT: Take care of yourself.

THE WITNESS: You, too.

(Witness excused)

THE COURT: All right, friends, what are we doing next?

MS. AGNEW: Your Honor, we have exhausted our witnesses for the day. I do think that we want to make our motion now, which you marked for the record earlier.

THE COURT: Counsel.

MR. MORRISON: Thank you, your Honor. I'll be brief.

Just to be clear, we're going to make a motion for a directive finding based on the opening questions that are relevant to this proceeding, and this motion is obviously just then based on the two witnesses called by the defendants, Dr. Moores and Dr. Khan.

To be clear, on December 23rd, 2022, the Court made an oral ruling on the plaintiffs' motions for injunctions, setting forth certain findings of facts based on the motion papers and the record itself. However, in such ruling, your Honor detailed three specific outstanding questions of facts that could not be resolved on the papers alone, and thus necessitated this evidentiary hearing.

As the defendants have rested their case calling two witnesses, Dr. Moores and Dr. Khan, plaintiffs are now moving for a directed verdict on that limited questions of fact this Court ordered to be addressed in this hearing. The three questions, which have seemed often at times peripheral to the testimony in this hearing that your Honor ordered evidence to

be presented on are as follows:

One, whether the conduct plaintiffs complained of in this lawsuit has, in fact, seized — it hasn't;

Two, whether there is a reasonable expectation that the violations will recur — yes; and

Three, whether policy 1.24A has completely and irrevocable eradicated the effects of the MWAP policy.

These three questions stem directly from the voluntary cessation that defendant Moores asserted in her response papers to plaintiffs' motions for injunctions. Specifically, Dr. Moores' assertion that DOCCS has mooted the plaintiffs' claims for injunctions because remedial measures have been taken by rescinding the MWAP policy and instituting policy 1.24A, which defendant Moores alleged cured all past violations and all past effects of the MWAP policy.

As this Court is aware, defendant Moores holds the burden with respect to each of these three questions by raising this defense. Courts are consistent that the burden for the voluntary cessation doctrine is a stringent and a heavy one. I cite American Freedom Defense Initiative v. Metropolitan Transportation Authority, 815 F.3d 105 (2d Cir. 2016). Here, Dr. Moores' evidence presented at the trial has failed to come even close to meeting that heavy burden.

I'll briefly, really briefly highlight why. First, and most importantly, I think what is clear, and this comes

from the testimony of Dr. Moores herself, policy 1.24A does nothing to even attempt to identify any of the patients in DOCCS custody that had their pain medication discontinued during the MWAP policy period. No attempts have been made to identify these patients by DOCCS to ensure that the deprivation of that medication that was requested by their providers at the time and denied by RMDs, who had no association, physical association with treating those patients have been reassessed and evaluated for what treatment they're receiving now in their pain management needs individually. Dr. Moores admitted she has the ability to identify these patients. I believe her testimony was that the central pharmacy can identify these patients, yet nothing has done to attempt to do so.

I also would add that on the face of policy 1.24A, it makes no mention of trying to cure any of those patients that were affected by MWAP. Dr. Moores admitted that the effects of the MWAP policy prevented patients from receiving optimal medication their providers deemed appropriate. Now that the MWAP policy has been rescinded for two years now, nothing has been done. Instead, DOCCS has done nothing but play whack a mole, chaotically reviewing patients that plaintiffs' counsel has identified for them and to the Court, spoonfed to them through discovery, but it's DOCCS that holds the information for all the patients that were affected, not the plaintiffs, and injunctions are necessary to ensure that DOCCS takes the

necessary efforts to identify, assess, and treat all the patients that suffered and to cure the continuing violations that those patients who still have not been provided that medication requested from their providers.

The second and other really important fact that came out during this hearing is that no efforts were done to train the providers on the new 1.24A policy. For two years now, this policy has been in effect, but no training has been implemented or even considered to be implemented on this policy. As set forth in plaintiffs' papers, patients remain losing their medication without assessments and transfer, losing effective medication without seeing or sitting down with a provider, as mentioned as a requirement in 1.24A, and these are the same exact issues that were occurring during the MWAP policy period that continue today, uncured.

I would like to briefly end with the last-minute efforts that Dr. Moores did testify she was undertaking through audits. Courts looked at effect of atonement of remedial measures to gauge the credibility and determine whether violations will likely reoccur. I'll cite to U.S. v. New York City Transit, 97 F.3d 672 (2d Cir. 1996); Ahrens v. Bowen, 852 F.2d 49 (2d Cir. 1988). Here, all of Dr. Moores' efforts and audits were done after the objections motions were filed and years after the policy 1.24A was implemented.

Plaintiffs admit, these are simply attempts to

manufacture a mootness argument for this litigation and avoid court intervention. Certain reviews that were discussed during the testimony occurred just a few months ago in November of '22, audits, by the way, that failed to even attempt to audit when providers failed to follow specialists' recommendations for a pain medication. Again, the failure to follow specialists' recommendations is the same issue that occurred under the MWAP policy and is an effect of the MWAP policy, and it continues today despite policy 1.24A.

In short, your Honor, the testimony of Dr. Moores and Dr. Khan has failed to meet the heavy burden required to establish mootness under the voluntary cessation doctrine. Policy 1.24A was implemented in February of 2021. For two years, DOCCS has done nothing to cure these effects. The fact that RMDs are no longer require to approve pain medication prescription is not what this hearing and this case is about. True, it is a good step to cure the barriers that the NY policy placed on patients, but that was a process change. This remedial measure does not fully respond to the plaintiffs' allegations of wrongdoing, and therefore cannot reasonably assure either the conduct at issue will not reoccur in the future or that its effects have been eradicated. And I'll cite to Davis v. City of New York 812 F.Supp.2d 333 (S.D.N.Y.2011).

The defendants have simply failed to meet their burden, the MWAP policies have not been cured by DOCCS, there

is nothing presented before the Court to believe that it will be cured by anything they are doing now. Patients continue to suffer, patients continue to remain in danger of losing their needed medication. Therefore, we respectfully request a directive finding to be ordered on these open questions pertinent to this hearing and that our motions be granted.

THE COURT: Thank you.

Ms. Kiley.

MS. KILEY: Yes. Thank you, your Honor.

As an initial matter, it appears that plaintiffs are making their motion for a directed verdict under Rule 50. Respectfully, Rule 50 does not apply. This is obviously not a jury trial. We will take their motion to be made under 52(c), which is a request for judgment on partial findings. That standard is whether defense had made a prima facie showing on the issues, which we believe that we have based on the testimony of Dr. Moores and Dr. Khan.

Whether the conduct has ceased, we want to draw attention to the fact that the complaint of conduct in the second amended complaint is that plaintiffs have had their medications discontinued based on a policy that, quote, stripped the medical treatment decisions from the providers at the hands of the regional medical directors. That is the complaint of conduct in the second amended complaint. The testimony we've heard from Dr. Moores and Dr. Khan

unequivocally shows that the RMDs are not involved in this process at all anymore. Providers are free to exercise their independent judgment when they treat a patient.

Dr. Moores has made it clear that there's no reasonable expectation that these violations will recur. The testimony is that the policy is no longer followed in any capacity. Dr. Moores also testified that she has no intention of reinstating the MWAP policy.

What was also made clear is that the difference between the MWAP policy and 1.24A is that the MWAP policy gave the regional medical directors the authority to step in on medical decisions, and 1.24A removed that authority. That is the difference and that is why MWAP can no longer be carried out in practice. The RMDs are not part of this process anymore.

I'd like to just touch on the argument that plaintiffs have made that Dr. Moores has made, quote, last-ditch efforts. Respectfully, your Honor, Dr. Moores officially became the chief medical officer in July of 2022, which was two months after the injunctions were filed. Any efforts that she made were not because of the injunctions, but because she felt that any changes she made were necessary. That was made clear in her declaration.

It is our position that it is abundantly clear that DOCCS is not a moving force behind the continuation of the MWAP

policy, and therefore we simply ask the Court to deny plaintiffs' motion.

Thank you.

THE COURT: Anything else, Mr. Morrison, that you wanted to add?

MR. MORRISON: No, your Honor.

THE COURT: Ms. Kiley, let me ask you one thing, please. I'm looking at the second amended complaint at paragraphs 1106 to 1108. I'll read it to you, you don't have to go if you don't want. I'm responding to your argument that the MWAP policy is rescinded and RMDs don't have any place in the policy and the prescription of these pain meds anymore.

The relief that plaintiffs are seeking is that the Court declare that the policy, practice, omission and conditions described above are in violation of the rights of plaintiffs and members of the class secured by the Eighth Amendment. And then I'm just adding a portion here, that the Court permanently enjoin "defendants, their agents, et cetera, et cetera, et cetera, from subjecting plaintiffs and members of the class to the illegal policies, practices, omissions, and conditions described in the second amended complaint." And then I'm just adding here, that the Court direct "defendants to allow individualized assessments of class members' MWAP needs by their primary care physicians, consultants, and specialists based on medically appropriate review with the patient's

medical history, physical exam, consideration of real functions; and where those efforts fail, ordering assessment by a properly certified, independent pain management specialist; and, creating a monitoring person or a body to ensure that patients who require MWAP medications are not denied based on anything other than a comprehensive individualized assessment."

So I think the question is, wasn't Mr. Morrison right at the end of his presentation, when he said the fact that the RMDs are no longer required to approve pain meds is not what this hearing is about. And I'll refer you to what I read from the complaint, it's about the conditions that the complaint alleges to continue to persist on the ground.

MS. KILEY: Your Honor, the role of the RMD is so significant in the MWAP policy, and that has been made clear, and removing them from the prescription of pain medication is a tremendous and significant effort. All we have heard today is that the decision to prescribe for pain medication comes from the provider, they are free to exercise their independent judgment, and that is what they are doing.

THE COURT: We have certainly heard testimony to the effect that the providers on the ground are not doing so consistent with their best medical judgment, but, if the witnesses are to be believed, are doing so based on items such as we don't do those meds at this facility.

MS. KILEY: Respectfully, that testimony was not part

of our case. We only presented Dr. Moores and Dr. Khan. As we understand it, this motion is being made solely after we rested and that the Court was not going to consider anything that came on to support plaintiffs' position.

THE COURT: What do you say, then, to the suggestion in the amended complaint that the conditions still persist and that DOCCS has not done anything to train the providers on the ground in connection with the new policy, 1.24A, and has made no effort to identify patients who might have been harmed by the prior policy?

MS. KILEY: There has been no evidence of any ongoing constitutional violation that was presented here or in the record.

THE COURT: So not training on the new policy and not making any effort to identify folks who were impacted negatively by the prior policy is sufficient for the Court, you say, to find that the conduct complained of has completely ceased, there's no reasonable expectation the violation will reoccur, and the new policy has eradicated the effects of the old policy.

MS. KILEY: Your Honor, the reason that the medications were discontinued under MWAP is because there was a mechanism in place --

THE COURT: I got that. I got that.

MS. KILEY: What I'm saying is that 1.24A on its face

is -- there's is objective administrative criteria that needs to be followed and we understand that. Training, to the extent that there might be some evidence that there's lack of training, is not indicative of ongoing constitutional violation. The constitutional violation --

THE COURT: How about whether 1.24A will eradicate the effects of MWAP? How do I know that based on no training?

MS. KILEY: There's no evidence in the record of who is an MWAP victim at this point, your Honor.

THE COURT: I'm not sure that's the issue either. If there's no training of the people on the ground, how can I make a finding of mootness that includes there's no reasonable expectation the violation will reoccur and the new policy has completely eradicated the effects of the old policy?

MS. KILEY: Respectfully, your Honor, Dr. Moores didn't even allude to the fact that providers need training on how to exercise their medical judgment. The complaint has to do with decisions based on nonmedical justifications, and Dr. Moores and Dr. Khan repeatedly testified that decisions are based on the medical judgments of the providers.

THE COURT: Thank you. Mr. Morrison, do you have anything you want to add?

MR. MORRISON: I did, but it's ran away from my mind.

THE COURT: It's late in the day.

All right, counsel. Reserved.

What time do you want to come in, friends, to be sure you finish tomorrow?

MS. AGNEW: We're just checking to see what time the video link is set for. My calendar has 9 o'clock.

THE COURT: I can do 9:00 if you can do 9:00.

MS. AGNEW: Your Honor, what if we did 9:30 just so we can interface with the facility and make sure -- the other thing is we also have two interpreters coming in because they have all these rules about how long they interpret.

THE COURT: Is that all right with you folks, 9:30?

MS. KILEY: Yes, your Honor.

THE COURT: Good enough. Thank you, friends. Good evening.

(Adjourned to February 8, 2022 at 9:30 a.m.)

* * *

INDEX OF EXAMINATION

PLAINTIFF EXHIBITS